Plan, including making benefit determinations, and is financially responsible for paying benefits. *Id.* at 5a.

Mr. Kobs applied for and received short-term disability benefits from UWIC for a period of six months. *Id.* at 3a. He subsequently applied for long-term benefits, because he could not perform the material duties of his regular occupation due to the severe injuries suffered from his fall. *Id.* at 3a, 34a. Based on his salary, long-term benefits payments would have totaled more than $4,700 per month, amounting to approximately $110,000 during the first 24 months of the long-term benefit period and potentially an additional $710,000 over the remaining term of the policy. *Id.* at 33a-34a, 39a, 47a-49a (stating that benefits are two-thirds of original salary and are paid until age 65).

Several months after UWIC ceased payment of benefits, Mr. Kobs attempted to work as a loan officer but had "trouble doing the paperwork . . . such as organizing the mortgage application file in the proper sequence," and was asked to resign after three months. *Id.* at 60a, 82a.

On October 22, 2002, UWIC denied long-term benefits based upon the opinion of a physician hired by UWIC who reviewed Mr. Kobs's medical records but never directly examined him. *Id.* at 50a-53a, 88a-90a. Pursuant to an internal appeal by Mr. Kobs, UWIC thereafter considered additional evidence. *Id.* at 3a. The record on appeal included three opinions of physicians who directly examined Mr. Kobs and diagnosed him with physically and cognitively disabling conditions.[1] Three opinions

---

[1] Dr. Neal Melby, Mr. Kobs's primary care physician, diagnosed Mr. Kobs with musculoskeletal injury and cognitive disability, including memory loss, and stated that Mr. Kobs is "chronically disabled and . . . unable to pursue gainful employment." Pet. App. 54a-61a. Dr. Mary Fisher, a psychologist, concluded that Mr. Kobs suffered "from deficits in executive functioning including sequencing,

from examining physicians and a psychologist, one hired by UWIC and another by a workers' compensation insurer, supported UWIC's position.[2] UWIC also hired two additional physicians and one nurse, not to conduct examinations of Mr. Kobs, but merely to review his medical records. *Id.* at 88a-91a. Each of these UWIC-retained reviewers supported UWIC's position. *Id.*

On September 4, 2003, despite the medical opinions of three examining physicians who concluded that Mr. Kobs suffered from disabling conditions, UWIC upheld the denial of benefits, stating that it "lack[ed] objective medical evidence to support the numerous subjective complaints and [found] no basis for a physically disabling condition." *Id.* at 92a-94a.

Having exhausted his appeals within UWIC, Mr. Kobs filed suit in Wisconsin state court to compel payment of

---

planning, mental organization, and mental control" and met "the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury." *Id.* at 62a-67a. Dr. Thomas Reiser, an orthopedic surgeon who treated Mr. Kobs, performed an examination in May 2002 and diagnosed him with "cervical" and "lumbar" conditions constituting a "permanent partial disability to the body as a whole . . . ." *Id.* at 68a-71a.

[2] Dr. Nolan Segal stated that "[i]t does appear that [Mr. Kobs] had a significant change in his overall abilities to function on several levels following his home-related fall of January 2002," but opined that Mr. Kobs was not disabled from a "musculoskeletal standpoint." *Id.* at 72a-75a. Dr. Mary Sullivan, a psychologist, diagnosed Mr. Kobs with a "psychological disturbance . . . which would render it difficult for him to be a fully engaged worker." *Id.* at 79a. Nonetheless, she concluded that he was not "cognitively disabled or memory impaired." *Id.* at 76a-80a. Dr. Sullivan also noted that she believed Mr. Kobs's "performance" on her evaluations "raise[d] questions about the effort he exerted," but she concluded that Mr. Kobs had not acted "deliberately, e.g., with the intent to deceive." *Id.* at 77a-78a. Philip Sarff, Ph.D., a psychologist hired directly by UWIC, stated that Mr. Kobs's "pattern of deficits is not consistent with degenerative dementia." *Id.* at 81a-86a.

his long-term disability benefits. *Id.* at 1a. UWIC then removed to federal district court.[3] *Id.* As part of his discovery efforts, Mr. Kobs requested a deposition of a UWIC employee in order to determine whether UWIC acted under "a perpetual conflict." Mr. Kobs argued that pursuant to this Court's decision in *Firestone*, a heightened standard of review was warranted in such instance. *Id.* at 105a. UWIC moved for a protective order, which the district court granted, stating that it was "of the opinion that a deposition is not required to determine the administration [sic] record in this matter."[4] *Id.* at 19a. Without the benefit of further discovery, Mr. Kobs's case proceeded to summary judgment solely on the basis of the administrative record before UWIC. *Id.* at 12a-14a.

In separate proceedings, Washington Mutual Bank and Daimler Chrysler Services filed suit in state court against Mr. Kobs and his wife to foreclose on their home and to reclaim their car.[5] *Id.* at 95a-99a. Both lending institutions were ultimately successful, and Mr. and Mrs. Kobs lost their house and car. *Id.* at 100a-103a.

---

[3] Jurisdiction in the district court was founded upon 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331. *Id.* at 10a.

[4] UWIC's motion relied upon *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999), which held that under a highly deferential arbitrary and capricious standard, "[t]here should not have been any inquiry into the thought processes of [the dual-role insurer's] staff . . . ." Pet. App. 107a-109a.

[5] Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk of this Court proposing to lodge certified copies of the state court complaints and judgments, which are a proper subject of judicial notice. *See generally* Fed. R. Evid. 201; Robert L. Stern et al., *Supreme Court Practice* 651-52 (8th ed. 2002).

In an order issued on May 28, 2004, the district court granted summary judgment in favor of UWIC. *Id.* at 18a. The district court first noted that the Plan provided UWIC "discretion to determine plaintiff's eligibility for benefits . . . ." *Id.* at 15a. Citing this Court's decision in *Firestone*, the district court found that in view of UWIC's conferred discretion, the highly deferential "arbitrary and capricious" standard applied to review UWIC's denial of benefits. *Id.* Although the district court recognized that under *Firestone* "[t]he presence of an apparent conflict of interest is a factor to be weighed when deciding whether an administrator's decision was arbitrary and capricious," *id.* (citing *Firestone*, 489 U.S. at 115), it remarked that "the Seventh Circuit has observed that conflict of interest concerns are minimal in the typical insurance context," *id.* at 16a (citing *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 408-90 (7th Cir. 2004)). The court then applied the highly deferential arbitrary and capricious standard and granted summary judgment in favor of UWIC. *Id.* at 18a.

2. On March 16, 2005, the Seventh Circuit affirmed on substantially similar grounds. *Id.* at 9a. Relying on its opinions in *Leipzig* and *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998), the court of appeals rejected Mr. Kobs's contention that UWIC acted under "an inherent conflict of interest due to its dual role as insurer and administrator of the Plan." Pet. App. at 5a-6a. Although it acknowledged the circuit split on the issue, the panel remarked that the Seventh Circuit "'presume[s] that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict.'" *Id.* (quoting *Mers*, 144 F.3d at 1020).

The Seventh Circuit then reviewed UWIC's decision under the highly deferential "arbitrary and capricious standard," articulating its judicial role as one limited to

determining "whether the administrator's decision was *completely unreasonable*." *Id.* at 6a-8a (emphasis added). Without considering the effect of UWIC's conflict of interest on its denial of Mr. Kobs's benefits, the Seventh Circuit relied on the medical reports in favor of UWIC's position to conclude that the denial was not "completely unreasonable." *Id.* The court of appeals expressly commented on the importance of the standard of review to its judgment: "A more fundamental problem with Kobs' arguments is that he fails to account for the deferential standard of review that we apply to UWIC's decision." *Id.* at 9a.

On March 30, 2005, Petitioner timely sought rehearing and rehearing en banc, which the Seventh Circuit denied.[6] *Id.* at 21a. This petition followed.

REASONS FOR GRANTING THE WRIT

Eleven circuits are divided over whether a dual-role insurer acts under an inherent conflict to be considered in the judicial review of a denial of benefits. Moreover, the circuits are split as to the appropriate means to consider such a conflict of interest. This division of authority frustrates ERISA's core aim "to provide a *uniform* regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S. Ct. 2488, 2495 (2004) (emphasis added). The lack of uniformity is of serious consequence to the millions of employees and their dependents who participate in ERISA plans and affects the adjudications of thousands of cases filed each

---

[6] On April 21, 2005, the Social Security Administration awarded Mr. Kobs disability benefits, finding that he "has been disabled since January 3, 2002." *Id.* at 22a-31a. Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk proposing to lodge certified copies of the decision, which is a proper subject of judicial notice. *See* Fed. R. Evid. 201.

year to recover benefits due. The Seventh Circuit's decision also conflicts with the rationale of this Court's decision in *Firestone* and the objectives of ERISA.

I. The Circuit Courts Are Intractably Divided Over the Questions Presented

ERISA is a comprehensive statute governing employee pension and welfare programs.[7] At the time of ERISA's enactment, participation in private employer benefit programs had been growing for a hundred years, and with this increased popularity had come increased awareness of potential abuses.[8] A principal policy objective of ERISA is to eliminate these abuses by "protect[ing] . . . the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(c).

Private benefits plans governed by ERISA may be structured in a variety of fashions:

> First, the employer may fund a plan and pay an independent third party to interpret the plan and make plan benefits determinations. Second, the employer may establish a plan, ensure its liquidity, and create an internal benefits committee vested with the discretion to interpret the plan's terms and administer benefits. Third, the employer may pay an independent insurance company to fund, interpret, and administer a plan.

Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 383 (3d Cir. 2000). The present case involves the third structure.

---

[7] Pub. L. No. 93-406, 88 Stat. 832 (1974) (codified as amended at 29 U.S.C. § 1001 et seq.).

[8] *See, e.g.*, Paul J. Schneider & Barbara W. Freedman, *ERISA: A Comprehensive Guide* §§ 1.02-1.05 (2d ed. 2003).

Under 29 U.S.C. § 1132(a)(1)(B), if an ERISA administrator denies benefits, a claimant may file suit "to recover benefits due to him under the terms of his plan . . . ." No statutory provision dictates the standard of review to be afforded under this section, and the courts have historically fashioned applicable standards.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court clarified conflicting lower court case law concerning the appropriate standard of review in certain § 1132(a)(1)(B) actions. This Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

If discretion is provided, this Court noted in dicta that "[t]rust principles make a deferential standard of review appropriate . . . ." *Id.* at 111. *Firestone* further states in dicta, that if a "benefit plan" subject to ERISA "gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'" by the administrator.[9] *Id.* at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

---

[9] The "abuse of discretion" standard discussed by this Court in *Firestone* emanates from trust law, whereas the "arbitrary and capricious" standard that the Seventh Circuit applied in this case derives from administrative law. Despite *Firestone*'s reliance on trust principles, most circuit courts have equated the two standards in the ERISA context. *E.g.*, *Wright v. R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005).

A. There Is A Deep Split Among The Circuits Over Whether A Dual-Role Insurer Is Subject To An Inherent Conflict To Be Considered In The Judicial Review Of A Denial Of Benefits

Since *Firestone*, the courts of appeals have taken different approaches on whether the denial of benefits by "insurance companies that both fund a plan and are also ERISA plan administrators" involves an inherent conflict to be considered in the judicial review of a particular denial of benefits under § 1132(a)(1)(B). *Pinto*, 214 F.3d at 378 (examining the split in detail and cataloguing cases).

1. The majority of the circuits addressing the issue, including the Third, Fourth, Fifth, Sixth, Tenth, and Eleventh, have held that a dual-role insurer[10] is subject to an inherent conflict to be considered in judicial review. *Pinto*, 214 F.3d at 387-90; *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295-98 (5th Cir. 1999) (en banc); *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F.3d 118, 120-22 (10th Cir. 1994); *Doe v. Group Hospitalization v. Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993); *Miller v. Metropolitan Life Ins.*, 925 F.2d 979, 984-85 (6th Cir. 1991);[11] *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1561 (11th Cir. 1990).

---

[10] This petition uses the term "insurer" generically—i.e., to encompass any non-employer fiduciary that both administers and funds a plan by providing insurance-type benefits, such as traditional insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and the like.

[11] The Sixth Circuit has not been entirely uniform. *See, e.g., Yeager v. Reliance Standard*, 88 F.3d 376, 381-82 (6th Cir. 1996) (failing to consider how the conflict of interest affected the dual-role insurer's specific denial of benefits). In the last five years, however, the Sixth Circuit has followed the majority approach in its published opinions. *See Gismondi v. United Techs. Corp.*, 408 F.3d 295, 298-99

Courts recognizing that there is an inherent conflict of a dual-role insurer to be considered in judicial review emphasize the fiduciary nature of the insurer's relationship to the beneficiary, and how the insurer's profit motives interfere with that relationship of trust. As the Fourth Circuit explained in *Doe*:

> Undoubtedly, [the insurer's] profit from the insurance contract depends on whether the claims allowed exceed the assumed risks. To the extent that [the insurer] has discretion to avoid paying claims, it thereby promotes the potential for its own profit .... Even the most careful and sensitive fiduciary in those circumstances may unconsciously favor its profit interest over the interests of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan.

3 F.3d at 86-87. *See also Vega*, 188 F.3d at 295-98; *Armstrong*, 128 F.3d at 1265; *Pitman*, 24 F.3d at 120-22; *Brown*, 898 F.2d at 1561.

In contrast, the First, Second, and Seventh Circuits hold that there is no inherent conflict of a dual-role insurer that should be considered in ıe judicial review of a specific denial of benefits. These circuits require an additional evidentiary showing beyond the dual-role relationship itself.[12] *Mers* 144 F.3d at 1020-21; *Doyle v.*

(6th Cir. 2005); *Carr v. Reliance Std. Life Ins. Co.*, 363 F.3d 604, 606 n.2 (6th Cir. 2004); *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527-28 (6th Cir. 2003).

[12] The Seventh Circuit requires that a "claimant show[] by providing specific evidence of actual bias that there is a significant conflict." *Mers*, 144 F.3d at 1020. Application of this requirement, along with the Seventh Circuit's decision in *Perlman*, *see supra* note 4, had a Kafkaesque result in this case. In order for the conflict to be

Paul Revere Life Insurance Co., 144 F.3d 181, 184 (1st Cir. 1998); *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477-78 (2d Cir. 1997) (citing *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 440-44 (2d Cir. 1995)).[13] In concluding that the conflicting fiduciary obligations of a dual-role insurer need not be taken into account in judicial review, these circuits have relied on unsubstantiated economic assumptions regarding the significance of the insurer's conflicting duties.[14] *See, e.g.*, *Mers*, 144 F.3d at 1021.

The Eighth Circuit originally adopted the majority approach, *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997), but later crafted a two-step hybrid approach for determining whether a conflict of interest should be considered, *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 (8th Cir. 1998). Under the *Woo* test, a claimant must show "that (1) a palpable conflict of

---

considered by the district court, it needed to be demonstrated by the introduction of specific evidence in the sole possession of the insurer. But the district court denied Mr. Kobs discovery on this issue based on its view that review must be limited to the administrative record under the arbitrary and capricious standard. *Id.* at 19a-20a.

[13] *But see Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (suggesting that a dual-role insurer is under a conflict that should "be weighed in determining whether there has been an abuse of discretion") (internal quotation marks and citations omitted). Despite *Pulvers*, cases within the Second Circuit continue to apply the arbitrary and capricious standard set forth in *Whitney*. *E.g.*, *Kirk v. Readers Digest Ass'n*, 57 Fed. Appx. 20, 25 (2d Cir. 2003).

[14] For instance, in *Mers*, the Seventh Circuit asserted, without reference to evidentiary support, that because the insurer's overall revenue was so large, the small payout would not provide enough of an incentive for self-dealing. *Mers*, 144 F.3d at 1021. The Seventh Circuit in *Mers* also supposed, again without evidentiary support, that it is in an insurer's long-term interest to grant meritorious claims so that employers and employees are sufficiently motivated to contract with the insurer. *Id.*

interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Id.* at 1160. Both *Woo* and later Eighth Circuit cases consider "evidence" that an ERISA administrator is a dual-role insurer sufficient to meet the first step of the test. *Id.*; *Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944, 947-48 (8th Cir. 2000). Unlike the majority approach, however, to satisfy the second part of the test, the claimant must "show that the conflict . . . has some connection to the substantive decision reached." *Woo*, 144 F.3d at 1161 (internal quotation marks and citations omitted).

Finally, the Ninth Circuit has published inconsistent panel opinions on the issue. In *Atwood v. Newmont Gold*, 45 F.3d 1317, 1322-23 (9th Cir. 1995), the Ninth Circuit concluded that in the absence of "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self interest caused a breach of the administrator's fiduciary obligations to the beneficiary," a conflict of interest need not be considered in judicial review of benefits denials. *Id.* at 1323. *See also Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996). Yet, in *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999), the court held that, even in the absence of specific evidence, "less deferential" review was warranted for a dual-role insurer.

2. This circuit split and its attendant confusion will not be resolved without this Court's intervention. The Seventh Circuit, despite being squarely in conflict with six circuits, declined in this case to reconsider its position en banc. Although a published opinion of the Second Circuit has expressed criticism of prior circuit precedent, *DeFelice v. American Int'l Life Assur. Co. of New York*, 112 F.3d 61, 66 n.3 (2d Cir. 1997), the Second Circuit has not undertaken full en banc review, *Kirk*, 57 Fed. Appx. at 25. The First Circuit has repeatedly applied its ruling

in *Doyle* and has also shown no inclination for en banc review. *See Wright v. R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 76 n.5 (1st Cir. 2005).

The views of the other circuits are also generally settled. The Fifth Circuit has already decided the issue en banc. *Vega*, 188 F.3d at 295-98. Three other circuits (the Sixth, Eighth, and Tenth) have denied requests for en banc rehearing on the issue.[15] The Third, Fourth, and Eleventh circuits have repeatedly applied the majority approach.[16] In contrast, the Ninth Circuit remains internally divided.[17]

This Court adverted to the unresolved question in *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest."). *See also* Transcript of Oral Argument at *6-*11 & *21, *Black & Decker Disability Plan v. Nord*, 538

---

[15] *Peach v. Ultramar Diamond Shamrock*, 109 Fed. Appx. 711 (6th Cir. 2004), *reh'g en banc denied* (Sept. 30, 2004), *cert. denied*, 125 S. Ct. 1641 (2004); *Glenn v. Life Ins. Co. of N. Am.*, 240 F.3d 679 (8th Cir. 2001), *reh'g and reh'g en banc denied* (Apr. 23, 2001), *cert. denied*, 534 U.S. 893 (2001); Petition for Writ of Certiorari, *Fought*, *cert. denied*, 125 S. Ct. 1972 (May 2, 2005) (No. 04-1000), 2005 WL 190349 at *6 (noting the denial of rehearing en banc).

[16] *See Kosiba v. Merck & Co.*, 384 F.3d 58, 64-66 (3d Cir. 2004) (examining "Pinto and Its Progeny"), *cert. denied sub nom. Merck & Co. v. Epps-Malloy*, 125 S. Ct. 2252 (2005); *Stup v. UNUM Life Ins. Co. of Am.*, 390 F.3d 301, 307 (4th Cir. 2004) (citing *Doe* and following cases); *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1135 (11th Cir. 2004) (same).

[17] *Compare Alford v. Dch Found. Group Long-Term Disability Plan*, 311 F.3d 955 (9th Cir. 2002) (applying the *Atwood* standard that there is no conflict to be considered in the absence of specific evidence) *with Nord v. Black & Decker Disability Plan*, 356 F.3d 1008 (9th Cir.) ("The district court recognized the apparent conflict of interest and reviewed the Plan administrator's decision with the special care required by *Firestone*."), *cert. denied*, 125 S. Ct. 62 (2004).

U.S. 822 (2003) (No. 02-469), 71 U.S.L.W. 3695, 2003 WL 21006122 (repeated questioning on the issue at oral argument).

Not only are ERISA participants and beneficiaries harmed by this unsettled question. In the interest of uniformity, two of the largest insurance industry trade organizations have expressed their desire to resolve the issue:

> Of substantial concern to *amici* and their members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to actions under ERISA alleging wrongful denial of benefits when an insurer, or any other administrator or fiduciary, is operating under a conflict of interest.

Motion of America's Health Insurance Plans and the American Council of Life Insurers to File a Brief Amici Curiae in Support of the Petition and Brief Amici Curiae at 5, *Fought v. Unum Life Ins. Co. of America*, *cert. denied*, 125 S. Ct. 1972 (May 2, 2005) (No. 04-1000), 2005 WL 1334150.[18]

Finally, despite the vast number of cases discussing this widespread and important split, neither Congress by statute nor the Department of Labor by regulation has

---

[18] The petition for certiorari in *Fought* was filed after the Tenth Circuit reversed and remanded a district court decision that had originally granted summary judgment to the issuer. *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997, 1015 (8th Cir. 2004). As a result, there was no final judgment. *Id.* *Fought* also presented complex tangential issues, making it a poor vehicle for review. *See id.* at 1011-15.

resolved it.[19] In similar circumstances in *Firestone*, this Court recognized the need for judicial resolution, because "ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) . . . ." 489 U.S. at 109.

3. This case provides an ideal vehicle to resolve this circuit split. The judgment of the Seventh Circuit is final, Pet. App. 1a, 21a, the medical evidence is in conflict, and the Seventh Circuit expressly stated that its "deferential" standard of review was material to its decision, *id.* at 9a. By failing to consider the effect of UWIC's conflict of interest on its denial of Mr. Kobs's benefits, the Seventh Circuit used a highly deferential arbitrary and capricious standard. *Id.* at 5a-6a. In so doing, it found in UWIC's favor on summary judgment, despite the existence of what—under tests from other circuits—would qualify as genuine issues of material fact as to Mr. Kobs's medical condition. *See Pinto*, 214 F.3d at 393-95 (finding that summary judgment was inappropriate under a "heightened" arbitrary and capricious standard where physicians' opinions conflicted and "a factfinder could conclude that [the insurer's] decision to credit its doctors . . . was the result of self-dealing instead of the result of a trustee carefully exercising its fiduciary duties"); *Tremain*, 196 F.3d at 978 (holding under a less deferential standard that "[b]ecause there are genuine issues of material fact in dispute as to whether Tremain was disabled and as to whether she was a 'salesman,' her entitlement to benefits and the amount of those benefits may not be decided by summary judgment").

---

[19] Although the Secretary of Labor has issued regulations governing claims and determinations, including appeals of adverse benefit determinations, these regulations are silent on the proper standard of judicial review. *See* 29 C.F.R. 2560.503-1.

Finally, this case does not contain procedural irregularities or predicate factual or legal issues that would prevent this Court from reaching this question.

B. There Is A Three-Way Split Among Eleven Circuits Over What Approach Applies When A Conflict Is Present

1. When a conflict of interest is present, regardless of whether the ERISA fiduciary is an insurance company, and regardless of how that conflict is shown, the circuits have adopted three different means (and variants thereof) by which to consider a conflict of interest: [20]

a. "Sliding Scale" Tests

The Third, Fourth, Fifth, Sixth, and Seventh Circuits have consistently implemented a "sliding scale" test to consider a conflict of interest. Under this approach, generally "deference [is] lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80, 87 (4th Cir. 1993); *accord Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Vega v. National Life Ins. Services, Inc.*, 188 F.3d 287, 296 (5th Cir. 1999) (en banc); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 n.1 (7th Cir. 1998); *Miller v. Metropolitan*

---

[20] The second question presented concerns the appropriate means to consider the conflict of interest specifically of an insurer. *See supra* at i. There is a significant circuit split on this issue. *Compare, e.g., Doe*, 3 F.3d at 87; *Pinto*, 214 F.3d at 392; *Vega*, 188 F.3d at 287 (adopting sliding scale test) *with Brown*, 898 F.2d at 1566 (adopting burden shifting test) *with Fought*, 379 F.3d at 1004 (adopting modified burden shifting test). This section of the petition also discusses some cases involving non-insurers, as the circuits have generally not distinguished between insurers and non-insurers once a conflict is shown. *E.g., Yochum v. Barnett Banks Inc.*, 234 F.3d 541, 543-44 (11th Cir. 2000) (applying burden shifting approach of *Brown* to conflicted employer-fiduciary).

Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991). The First Circuit has adopted a "reasonableness" test, *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999), which is "something like the sliding scale" approach, *Pinto*, 214 F.3d at 392.[21]

b. "Burden Shifting" Tests

The Eleventh Circuit was the first to adopt a "burden shifting" approach. Under this test, "when a plan beneficiary demonstrates a substantial conflict of interest . . . the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990). Unlike a highly deferential arbitrary and capricious standard of review that does not take into account a conflict, under a burden shifting approach, "a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries." *Id.* at 1568.[22]

---

[21] The "sliding scale" courts typically focus on this Court's dicta in *Firestone* that the "conflict must be weighed as a factor in determining whether there is an abuse of discretion," 489 U.S. at 115 (internal quotation marks and citations omitted). *E.g.*, *Pinto*, 214 F.3d at 392 (noting derivation of sliding scale test from "*Firestone*'s dictate that a conflict should be considered as a 'factor' in applying the arbitrary and capricious standard"). The *Pinto* court itself, however, criticized the workability of this approach: "Once the conflict becomes a 'factor' however, it is not clear how the process required by the typical arbitrary and capricious review changes." *Id.*

[22] In adopting a "burden shifting" standard, the Eleventh Circuit relied on general principles of trust law. *Id.* at 1563-68. *Cf. Pinto*, 214 F.3d at 393 ("While the approach of . . . the Eleventh Circuit would seem more compatible with the basic principles of trust law, and hence

The Ninth Circuit applies a variant of the Eleventh Circuit's burden shifting test in situations where the claimant presents specific "evidence indicating that the conflicting interest caused a breach of the administrator's fiduciary duty." *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995).[23]

The Tenth Circuit in *Fought* provided substance to its "sliding scale" test to specifically answer the question of "how much less deference ought a reviewing court afford?" 379 F.3d at 1004. In so doing, the *Fought* court effectively bifurcated its sliding scale test into two tiers: first, "standard" conflicts of interest, wherein the conflict is considered as "one factor" in the overall review; and second, "inherent" conflicts (such as those of dual-role insurers), wherein the burden shifts to the plan administrator to "demonstrate that its interpretation of the terms of the plan is reasonable and that its application of those terms to the claimant is supported by substantial evidence." *Id.* at 1005-06.

c. *De Novo* Review

The Second Circuit—although finding a conflict only in the presence of particularized evidence of such—adopts a *de novo* review of any denials of benefits once a showing of a conflict is made. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996). Under the pure *de novo* approach of the Second Circuit, there is

---

a better 'fit', only the Supreme Court can undo the legacy of *Firestone*.").

[23] In cases finding an inherent conflict where no additional evidence has been presented, *see supra* Part I.A., the Ninth Circuit has indicated that a "less deferential" standard of review (though not burden shifting) is appropriate. *Tremain*, 196 F.3d at 976; *accord Nord*, 356 F.3d at 1008.

no burden shifting; rather, if a conflict of interest is shown, "the court interprets the plan *de novo*." *Id.*

The Eighth Circuit adopted a *de novo* standard in *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997).[24] Yet, in *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998), the court distinguished *Armstrong* as a case involving "egregious circumstances" and adopted a sliding scale test. The Eighth Circuit has not settled on a single approach. *See, e.g.*, *Harden v. Am. Express Fin. Corp.*, 384 F.3d 498, 500 (8th Cir. 2004) (endorsing sliding scale review); *Davolt v. Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000) (endorsing *de novo* and sliding scale standards).

2. Like the first question presented in this case, *see supra* Part I.A, this circuit split will not resolve itself without this Court's intervention. The circuits have applied these tests for many years, and a number of circuits have either decided the issue en banc or have rejected requests for rehearing en banc.[25] This Court's comments in *Rush Prudential* highlight the question of just what standard of review should apply in the face of a conflict. 536 U.S. at 384 n.15.

---

[24] In *Armstrong*, the Eighth Circuit articulated its rationale for a *de novo* standard as "informed by the reasoning of the Eleventh Circuit's holding in *Brown*, which stated that a relationship that places an ERISA benefits plan administrator in 'perpetual conflict' warrants a higher level of scrutiny." 128 F.3d at 1265 (quoting *Brown*, 898 F.2d at 1561).

[25] *E.g.*, *Stup*, 390 F.3d at 307 (noting repeated application); *Kosiba*, 384 F.3d at 64-66 (same); *HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-94 (11th Cir. 2001) (same); *Vega*, 188 F.3d at 295-98 (en banc decision); Petition for Writ of Certiorari, *Fought*, 2005 WL 190349 at *6 (noting refusal to reconsider en banc).

3. Like the first question presented, a decision on this second question will be material to the outcome of the present case. Specifically, if a conflict of interest is not considered, a plan fiduciary is granted significant deference such that evidence contradictory to that relied upon by the fiduciary will not typically create a genuine issue of material fact. *See supra* Part I.A. On the other hand, without such deference, contradictory evidence will often create a genuine issue of material fact so as to preclude summary judgment. *See id.* In view of the directly contradictory evidence in this case, and the likely role that UWIC's conflict of interest played in its denial of benefits, summary judgment in UWIC's favor was not appropriate.[26]

Because the facts here squarely present the issue and the case law in this area is well-developed, this Court should endeavor to resolve just how "peeled" the "judicial eye" should be in light of a conflict of interest.[27] *Rush Prudential*, 536 U.S. at 384 n.15.

---

[26] Under a burden shifting or *de novo* approach, the conflicting evidence in the record under review would preclude summary judgment. *E.g.*, *Tremain*, 196 F.3d at 978. Under a "sliding scale" approach, whether summary judgment is appropriate depends in part on the level of deference accorded to the fiduciary. *E.g.*, *Pinto*, 214 F.3d at 392.

[27] In so doing, this Court need not determine under the proper standard whether summary judgment was appropriate in this case. When deciding upon the appropriate standard of review, this Court has routinely determined the correct standard and then remanded the case to the circuit or district court to apply the proper standard "in the first instance." *Johnson v. California*, 125 S. Ct. 1141, 1152 (2005) (determining that the appropriate standard of review was "strict scrutiny" and remanding "the case to allow the Court of Appeals for the Ninth Circuit, or the District Court, to apply it in the first instance").

II. The Questions Presented Are Frequently Litigated And Of Manifest National Importance

A. Each Year, There Are Millions Of ERISA-Governed Benefits Determinations, Resulting In Thousands Of Lawsuits Challenging Denials Of Benefits

Resolution of the questions presented is of significant national importance. In 2005, according to the Bureau of Labor Statistics, Department of Labor, of roughly 110 million private employees nationwide, approximately 53% participated in health care plans; 50% in retirement benefits plans; 49% in life insurance plans; 39% in short-term disability plans; and 29% in long-term disability plans.[28] The total payout in 2004 under private pension, profit-sharing, and insurance plans was nearly $950 billion, approximately 8% of the U.S. gross domestic product that year.[29] Most of these plans are subject to ERISA. *See* 29 U.S.C. § 1002(1).

The Department of Labor estimates that ERISA fiduciaries and administrators deny more than 40 million

---

[28] Total Private Employment – Not Seasonally Adjusted, U.S. Department of Labor, Bureau of Labor Statistics, http://data.bls.gov/cgi-bin/surveymost?ce (last visited Sept. 21, 2005); National Compensation Survey: Employee Benefits in Private Industry in the United States, U.S. Department of Labor, Bureau of Labor Statistics 6, 9 (Mar. 2005), *available at* http://www.bls.gov/ncs/ebs/sp/ebsm0003.pdf.

[29] *See* Employer Contributions for Employee Pension and Insurance Funds by Industry and by Type, U.S. Department of Commerce, Bureau of Economic Analysis, http://www.bea.gov/bea/dn/nipaweb/TableView.asp?SelectedTable=208&FirstYear=2003&LastYear=2004&Freq=Year (last visited Sept. 21, 2005); Current-Dollar and "Real" Gross Domestic Product, U.S. Department of Commerce, Bureau of Economic Analysis, http://www.bea.gov/bea/dn /gdplev.xls (last visited Sept. 21, 2005).

claims annually. *See* Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70246, 70263 (Nov. 21, 2000). In 2003 alone, 750 lawsuits were filed in federal court under ERISA against just one of the nation's many dual-role insurers, UnumProvident.[30]

B. The Objectives Of ERISA To Promote Uniformity And To Protect Private Employee Benefits Are Thwarted By The Decision Below

The inconsistent decisions concerning the proper approach for reviewing denials of benefits by dual-role insurers contravenes ERISA's aim of providing a uniform, nationwide system of employee benefits. *See Aetna Health*, 124 S. Ct. at 2495. In the aggregate, insurers, employers, and employees needlessly suffer, because the lack of clear legal principles in this area unnecessarily raises costs for all parties. *Cf. FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."). A clear and workable set of rules will remove these burdensome costs

---

[30] The number of suits filed was determined by running a search on Lexis-Nexis Courtlink, available at http://www.courtlink.com, in all federal district courts for ERISA cases filed in 2003 with "Unum" or "UnumProvident" named as a defendant. Based on accounts of UnumProvident's recent settlement with the U.S. Department of Labor and many states regarding disability claims handling, it appears most of those cases are appeals of discretionary adverse benefit determinations under ERISA. *See, e.g.*, Peter A. Meyers, Comment, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 Seattle U. L. Rev. 925-927 (2005) (describing lawsuits against UnumProvident appealing denials of disability benefits under apparently discretionary plans).

by providing an across-the-board standard that insurers and employers can implement to gauge costs and provide maximal benefits to employees per dollar spent.

A clear and workable rule, however, need not provide effectively unbridled deference to a conflicted plan administrator. Another aim of ERISA, of course, is the accurate determination of benefit claims. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (noting ERISA's enforcement provision reflects "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans"). While ignoring the presence of a conflict certainly provides consistency and uniformity, it gives unwarranted immunity for insurers to reject meritorious claims. *Cf. Pinto*, 214 F.3d at 388 ("insurance carriers have an active incentive to deny close claims in order to keep costs down and keep themselves competitive so that companies will choose to use them as their insurers, an economic consideration overlooked by the Seventh Circuit."). ERISA was enacted to safeguard against these very abuses. *See Firestone*, 489 U.S. at 113 ("ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.").

Moreover, the Seventh Circuit's holding contravenes this Court's reliance in *Firestone* upon the common law of trusts as the appropriate framework to ensure that administrators follow their fiduciary obligations such that self-interest does not infect claims determinations. *Id.* at 110-11. An insurance company administering a benefits plan, like any trustee, is a fiduciary subject to both a duty of loyalty, 29 U.S.C. § 1104(a)(1)(A), and a duty of care, *id.*

§ 1104(a)(1)(B).[31] Under trust law principles any conflict that may compromise these duties justifies either voiding a decision tainted by the conflict or applying more scrutiny in reviewing such a decision.[32] Although ERISA contains an exception to the usual rule of trust law in order to allow dual-role insurers to administer plans, 29 U.S.C. § 1108(c)(3), that exception does not imply that conflicted insurers should receive the same level of deference as impartial fiduciaries.[33]

---

[31] *See also Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570-72 (1985) ("The manner in which trustee powers may be exercised, however, is further defined in the [ERISA] statute through the provision of strict standards of trustee conduct, also derived from the common law of trusts – most prominently, a standard of loyalty and a standard of care."); *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-332 (1981) (finding that ERISA imposes "an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties"). *Cf. Meinhard v. Salmon*, 164 N.E 545, 546 (N.Y. 1928) (Cardozo, J.) ("A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.").

[32] *See* Restatement (Second) of Trusts § 170(1) cmts. a-h (1959); *id.* at § 187. *Cf.* G. Bogert, *Trusts and Trustees* § 543, at 475-76 (2d ed. 1960) ("[I]t is generally, if not always, humanly impossible for the same person to act fairly in two capacities and on behalf of two interests in the same transaction. Consciously or unconsciously he will favor one side as against the other, where there is or may be a conflict of interest."). Of course, UWIC's fiduciary officers owe a duty of loyalty and duty of care not only to plan participants, but to UWIC's profit-seeking stockholders. *E.g., Western Industries v. Vilter Mfg. Co.*, 257 Wis. 268, 299 (Wis. 1950) ("It is their duty to administer the corporate affairs for the common benefit of all the stockholders, and exercise their best care, skill and judgment in the management of the corporation business solely in the interest of the corporation.") (internal citations and quotation marks omitted).

[33] *See Doe*, 3 F.3d at 86-87 ("But this consent does not mean that the fiduciary's judgment will not be scrutinized more closely than when he acts solely in the interest of the beneficiaries.").

The Seventh Circuit's analysis rests on unsubstantiated economic assertions effectively to adopt a *per se* rule that precludes clear conflicts under trust law from being considered in the judicial review of a denial of benefits. In fact, there is economic evidence directly contradicting these assumptions. In *Armstrong*, the Eighth Circuit noted that "[a]pparently to limit claim payments, Aetna provides incentives and bonuses to its claims reviewers based on criteria that include a category called 'claims savings.'" 128 F.3d at 1265. A deposed claims manager described "claims savings" as funds retained by Aetna on claims "not eligible" for benefits.[34] Pet. App. 111a. She also explained in detail how "claims savings" played a role in determining "merit increases" (i.e., bonuses) for claims adjusters, including several of her own bonuses. *Id.* at 112a-116a.

This sort of self-serving behavior is not limited to a single insurer. For example, an internal memorandum from another major insurance company confirms that a deferential standard of review emboldens ERISA fiduciaries to deny claims in close cases:

> The advantages of ERISA coverage in litigious situations are enormous . . . . [There] are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit[s] in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant . . . *While our objective is to pay all valid claims and deny*

---

[34] Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk proposing to lodge certified copies of the deposition filed with the court in *Armstrong*, which is a proper subject of judicial notice. *See* Fed. R. Evid. 201.

> *invalid claims, there are some gray areas, and ERISA applicability may influence our course of action.*

Id. at 117a-119a. (submitted as an exhibit to Plaintiff's Trial Brief, *Schneider v. Provident Life & Accident Ins. Co.*, No. C 97-4646 SC (N.D. Cal. Apr. 5, 1999)) (emphasis added).[35] *See also* Peter G. Gosselin, *The New Deal; The Safety Net She Believed In Was Pulled Away When She Fell*, Los Angeles Times, August 21, 2005, at A1 (describing claims adjudication practices of disability insurers).

Finally, and perhaps most importantly, the Seventh Circuit's view is directly contrary the policy objectives of ERISA to provide remedies to *individual*, injured workers. *Cf. Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) ("ERISA specifically provides a remedy for breaches of fiduciary duty with respect to the interpretation of plan documents and the payment of claims . . . that runs directly to the injured beneficiary."). Even if, as the Seventh Circuit predicts, employers will "[i]n the long run . . . leave" an insurer that denies meritorious claims, this views fails to vindicate the rights of *current* beneficiaries. Whether Mr. Kobs's former employer continues to use UWIC as its plan administrator has no bearing on Mr. Kobs's present right to benefits.

That UWIC was under a conflict of interest in making its benefit determination, however, did have a bearing on Mr. Kobs's right. Under the rationale of this Court's decision in *Firestone*, the impact of that conflict must be

---

[35] Pursuant to Supreme Court Rule 32.3, Petitioner has written to the Clerk proposing to lodge certified copies of the trial brief and exhibit, which are a proper subject of judicial notice. *See* Fed. R. Evid. 201.

"weighed" in the judicial review of UWIC's denial of benefits. Moreover, in view of the widespread divergence among the circuits over how a conflict of interest should be weighed, and the importance of national uniformity under ERISA, determining the appropriate means to consider such a conflict is crucial.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

LAURA W. BRILL
Counsel of Record
TED M. SICHELMAN
IRELL & MANELLA, LLP
1800 Avenue of the Stars
Los Angeles, California 90067
(310) 277-1010

JASON W. WHITLEY
NOVITZKE, GUST, SEMPF
& WHITLEY
314 Keller Avenue North,
Suite 399
Amery, Wisconsin 54001
(715) 268-6130

Counsel for Petitioner Elvis Kobs

September 23, 2005

TABLE OF CONTENTS

APPENDIX

400 F.3d 1036

United States Court of Appeals,
Seventh Circuit.
Elvis KOBS, Plaintiff-Appellant,
v.
UNITED WISCONSIN INSURANCE COMPANY,
Defendant-Appellee.
No. 04-2483.

Argued Jan. 20, 2005.
Decided March 16, 2005.
Rehearing and Rehearing En Banc Denied April 26, 2005.

Jason W. Whitley (argued), Novitzke, Gust, Sempf & Whitley, Amery, WI, for Plaintiff-Appellant.

Carol L. Dorner (argued), United Wisconsin Group, Milwaukee, WI, for Defendant-Appellee.

Before FLAUM, Chief Judge, and BAUER and KANNE, Circuit Judges.

BAUER, Circuit Judge.

Plaintiff-appellant Elvis Kobs suffered injuries in January 2002 when he fell off his roof while removing Christmas ornaments. Following the accident, Kobs received short-term disability benefits from his disability insurance carrier, defendant-appellee United Wisconsin Insurance Company ("UWIC"), but his subsequent application for long-term disability benefits was denied. After an unsuccessful appeal of that determination, Kobs filed suit in state court, and UWIC removed the case to federal court, as the plan at issue is governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001, *et seq.* The district court granted summary judgment in favor of UWIC. We affirm.

I. Background

Prior to his January 2002 fall, Kobs was a business manager at Bernard's Northtown car dealership in New Richmond, Wisconsin. This sedentary job required him to sit eighty percent of the day, stand twenty percent of the day, and lift up to five pounds. Kobs was a participant in a group disability insurance plan (the "Plan") issued by UWIC to Bernard's Northtown, and the Plan offered both short-term and long-term benefits. With regard to short-term benefits, the Plan states: "You are disabled if, because of illness or injury, you are unable to perform with reasonable continuity, the material duties of the occupation that you regularly perform for this group." The Plan generally provides long-term disability benefits when an insured is "Totally Disabled," defined, in relevant part, as follows:

> **"TOTAL DISABILITY"** and **"TOTALLY DISABLED"** means that due to Injury and/or Illness:
>
> 1. The Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the Benefit Period; and
>
> 2. After 24 months of the Benefit Period, the Insured cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training, or experience.

The Plan also confers discretion upon UWIC to determine eligibility for benefits:

BENEFIT DETERMINATION

Benefits under this policy will be paid only if United Wisconsin Insurance Company decides in its discretion that the Insured is entitled to them.

Kobs applied for short-term disability benefits immediately after the January 2002 accident. UWIC approved his application and paid him short-term disability from January 2, 2002, until July 4, 2002, when his short-term benefits were exhausted. Kobs then applied for long-term disability benefits. Kobs claimed that he could not perform the material duties of his regular occupation because he suffered from various conditions, most notably memory loss resulting from incidents in 1998 and 1999 and exacerbated by his fall in 2002. In an October 2002 letter, UWIC denied Kobs' claim for long-term disability benefits, explaining that "the medical information does not support an inability to perform the duties of your occupation, after July 4, 2002." After Kobs appealed the determination, UWIC received and reviewed additional medical information and then upheld the denial of benefits. The denial letter stated, "We lack objective medical evidence to support the numerous subjective complaints and find no basis for a physically disabling condition."

UWIC considered a number of medical opinions and records in arriving at its decision. The opinions weighing in Kobs' favor came from Dr. Neal Melby, his primary care physician, and Dr. Mary Fischer, a psychologist who saw Kobs on a referral from Dr. Melby. Dr. Melby opined on several occasions that Kobs was disabled both as a result of "musculoskeletal problems" (injuries to his back and legs) and as a result of cognitive disability, including memory loss. Dr. Fischer met with Kobs to evaluate his complaints of memory loss, headaches, and cognitive

difficulties. After conducting psychological tests on Kobs, she concluded that he suffered "from deficits in executive functioning including sequencing, planning, mental organization, and mental control" and "global memory deficits," and met "the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury." In addition, Dr. Thomas Reiser of the Midwest Spine Institute saw and evaluated Kobs in 1999, then reviewed Kobs' medical records in 2002 and stated that he had "a permanent partial disability of 4% to the body as a whole" under applicable workers' compensation law.

On the other side of the scale were the opinions of two orthopedic surgeons, two psychologists, a psychiatrist/neurologist, and a registered nurse. Dr. Nolan Segal, an orthopedic surgeon, performed an independent medical evaluation of Kobs in January 2003 and concluded that there was "no evidence [that Kobs] would be considered disabled from a musculoskeletal standpoint." Dr. Richard Silver, also an orthopedic surgeon, reviewed Kobs' medical file at UWIC's request and concluded that Kobs was "fit for duty at a sedentary light capacity . . . from an orthopedic perspective." Dr. Mary Sullivan, a psychologist who saw Kobs on a referral from Dr. Melby, performed a neuropsychological evaluation of Kobs in August 2003 and concluded that Kobs was not "cognitively disabled or memory impaired." Dr. Sullivan also noted that "there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout the evaluation." Dr. Reginald Givens, a psychiatrist and neurologist hired by UWIC to review Kobs' file, concluded that "Kobs does not have a significant impairment that would impair him from performing essential functions of his employment." Dr. Philip Sarff, a psychologist hired by

UWIC, evaluated Kobs in March 2003 and opined that Kobs' "pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury." In addition, Sarff noted that "there is strong evidence that [Kobs] consciously or unconsciously exaggerated symptoms for this evaluation." The final opinion came from Francine Blaha, a nurse who reviewed Kobs' entire file at UWIC's request prior to its decision on Kobs' appeal. Blaha recommended that UWIC uphold the denial of long-term disability benefits because "the objective data does not even come close to the massive subjective complaints of the claimant."

II. Discussion

Kobs leads with a challenge to the district court's decision to apply the arbitrary and capricious standard to review UWIC's benefits determination. Citing case law from other circuits, Kobs argues that UWIC has an inherent conflict of interest due to its dual role as insurer and administrator of the Plan. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir.2000) (collecting cases). We have considered and rejected similar arguments on numerous occasions, most recently in *Leipzig v. AIG Ins. Co.*, 362 F.3d 406 (7th Cir.2004), and we see little reason to revisit those opinions or add to their analysis. As we explained in *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir.1998), "[w]e presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." Because Kobs has not presented any specific evidence of a conflict of interest and because the Plan contains a grant of discretionary authority that closely tracks the "safe

harbor" provision we drafted in *Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir.2000), we agree with the district court that reversal is only warranted if the administrator's decision was arbitrary or capricious. Under the arbitrary and capricious standard, we do not ask whether the administrator reached the correct conclusion or even whether it relied on the proper authority. *Cvelbar v. CBI Ill. Inc.*, 106 F.3d 1368, 1379 (7th Cir.1997). Instead, the only question for us is whether the administrator's decision was completely unreasonable. *Manny v. Cent. States, Southeast and Southwest Areas Pension and Health and Welfare Funds*, 388 F.3d 241, 243 (7th Cir.2004).

Kobs argues that UWIC's decision was arbitrary and capricious because his treating physician, Dr. Melby, concluded that he was disabled. This argument is unpersuasive for a number of reasons. First, ERISA does not require plan administrators to accord special deference to the opinions of treating physicians. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S.Ct. 1965, 155 L.Ed.2d 1034 (2003) (rejecting Ninth Circuit's decision to import the "treating physician" rule from the Social Security context). Second, Kobs makes no effort to address the medical opinions that undermine Dr. Melby's conclusions and support UWIC's determination. Two orthopedic surgeons rejected Dr. Melby's opinion that Kobs was totally disabled due to "musculoskeletal problems," and concluded that he was not disabled from a musculoskeletal standpoint. It makes little sense to give great deference to Dr. Melby's opinion about Kobs' "musculoskeletal problems" when it is contradicted by two physicians who specialize in musculoskeletal injuries. *Black & Decker*, 538 U.S. at 832, 123 S.Ct. 1965. In light of the opinions of the two specialists, it was neither arbitrary nor capricious for

UWIC to conclude that Kobs' claimed physical impairments did not prevent him from performing the material duties of his sedentary job.

The medical evidence regarding Kobs' asserted cognitive impairments also supported UWIC's denial of long-term disability benefits. Dr. Melby referred Kobs to both Dr. Fischer and Dr. Sullivan for psychological testing. While Dr. Fischer diagnosed Kobs with dementia due to traumatic brain injury and global memory deficits, Dr. Sullivan strongly disagreed, concluding that Kobs was not cognitively disabled or memory impaired. Dr. Sullivan, who was not on UWIC's payroll, was also the first of three medical experts who questioned whether Kobs was sandbagging during the tests:

> [T]here are numerous implausible aspects of his performance . . . . First of all, Mr. Kobs' IQ, as measured here, was found to be 80, that is, just barely within the low average range. This is simply not believable. There is no possible way that a head injury of the severity described by Mr. Kobs could have lowered his IQ to this level. Furthermore, there were findings within the IQ testing that were also highly unlikely. Mr. Kobs obtained a score on Vocabulary, which measures knowledge of vocabulary, that was in the low average range. This seems unusually low for a man who finished two years of Boston College and who used to make speeches and sell cars . . . . Furthermore, knowledge of vocabulary is pretty invulnerable to the effects of a mild head injury . . . . Third, Mr. Kobs got just one item right on Picture Arrangement – the first item. He then failed the next four items. This is a ***highly unusual*** performance, even for people who are mentally retarded. Mr. Kobs, even given how poorly he performed, is clearly not mentally retarded.

Ex. M to Szemborski Aff. (emphasis in original). Psychologist Philip Sarff concurred with Dr. Sullivan's assessment that Kobs was exaggerating his symptoms. Dr. Givens and Francine Blaha, a psychiatrist and nurse, respectively, also agreed that Kobs' complaints about cognitive impairments did not match the objective medical evidence. The foregoing medical opinions provided UWIC with reasonable support for its denial of Kobs' long-term disability application.

Kobs also describes the Plan's short-term disability definition and long-term disability definition as "nearly identical," arguing that the disability finding for short-term benefits should have led to a disability finding for long-term benefits. This argument ignores the plain language of the Plan. A Plan participant is "Totally Disabled" under the Plan and thus entitled to long-term disability if (1) he cannot perform the material duties of his position for 30 months (the elimination period plus the benefit period) *and* (2) he cannot perform any of the material duties of any gainful occupation for which he is reasonably suited *after* those 30 months. In contrast, a Plan participant is entitled to short-term benefits if he is unable to perform the material duties of his position during the short-term benefits period. Thus, the provisions are different because they are premised on different time frames and because a worker that qualifies for short-term benefits may not be entitled to long-term benefits if he possesses the ability to perform the duties of *another* occupation for which he is suited. As a consequence, it was not arbitrary and capricious for UWIC to interpret the Plan in a way that granted Kobs short-term benefits and denied him long-term benefits.

A more fundamental problem with Kobs' arguments is that he fails to account for the deferential standard of review that we apply to UWIC's decision. UWIC gathered and reviewed the pertinent medical information, hired a number of physicians to evaluate Kobs and review his medical files, and made an informed judgment about Kobs' long-term disability application that coincided with the bulk of the medical evidence. When Kobs appealed the initial determination, UWIC accepted additional medical information submitted by Kobs, had another psychologist evaluate Kobs, and hired a nurse to review Kobs' entire file. Given this exhaustive process, UWIC's reasonable conclusions, and the absence of evidence of bad faith or conflict of interest, there is no basis to disturb UWIC's benefits determination.

III. Conclusion

For the reasons stated herein, we AFFIRM the decision of the district court.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS,

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Defendant.

MEMORANDUM AND ORDER
04-C-005-S

(Filed May 28, 2004)

Plaintiff Elvis Kobs commenced this action in Polk County Circuit Court against defendant United Wisconsin Insurance Company seeking benefits allegedly due under a long-term disability policy governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461. Defendant removed pursuant to 28 U.S.C. § 1441(a). The Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e)(1). The matter is presently before the Court on defendant's motion for summary judgment. The following facts are those most favorable to plaintiff.

BACKGROUND

Plaintiff Elvis Kobs was a participant in a long-term disability (LTD) group insurance policy issued by defendant United Wisconsin Insurance Company to plaintiff's former employer Bernard's Northtown, Inc. Bernard's Northtown is a car dealership located in New Richmond, Wisconsin. Plaintiff was employed by Bernard's Northtown as a business manager. This sedentary job required him to

sit eighty percent of the day and stand the other twenty. The job required some light lifting of no more than five pounds.

On January 7, 2002, plaintiff applied for disability benefits after sustaining injuries when he fell from his roof. In June 2002, plaintiff underwent an angioplasty after experiencing chest pain. Defendant paid short-term disability benefits to plaintiff from January 2, 2002 through July 4, 2002. Plaintiff requested LTD benefits after exhausting his short-term benefits.

Defendant retained an orthopedic surgeon and a psychiatrist/neurologist to review plaintiff's file. Defendant denied plaintiff's request for LTD benefits stating that it determined that the medical documentation it received did not support plaintiff's inability to perform the material duties of his regular occupation after July 4, 2002.

Defendant offered to review any additional information that plaintiff wished to furnish in support of his disability claim. Plaintiff requested an appeal and submitted additional medical documentation. Defendant obtained documents from the Wisconsin Department of Workforce Development relating to plaintiff's workers' compensation claims for incidents in 1998 and 1999. Defendant also requested that plaintiff undergo an independent psychological evaluation as permitted under the plan. Defendant then retained a board certified psychiatrist/neurologist to review the additional documentation it had gathered during the appeal process. Finally, a registered nurse performed a complete review of plaintiff's file.

On August 27, 2003, defendant's appeal committee convened to review plaintiff's claim. The committee

included representatives from a number of defendant's departments: the Disability and Life Claims Manager, claims representatives, registered nurses, and the workers Compensation Claims Manager. The committee upheld defendant's decision to deny plaintiff's LTD benefits. On September 4, 2003, defendant sent plaintiff a letter outlining the Committee's decision. Plaintiff's administrative remedies exhausted, he commenced the present action.

The following is a summary of the medical reports in the record considered by defendant in denying plaintiff's claim:

(1) Dr. Neal Melby is plaintiff's primary care physician. He opined on several occasions that plaintiff was disabled both as a result of injury to his back and legs and as a result of cognitive disability including memory loss.

(2) Dr. Thomas Reiser is a doctor at the Midwest Spine institute. He saw and evaluated plaintiff in 1999 for back and arm pain and headaches. In a letter of July 30, 2002, he opined "after reviewing the available information" that plaintiff has "a permanent partial disability of 4% to the body as a whole . . . " under applicable workers compensation law.

(3) Dr. Nolan Segal is an orthopedic surgeon who performed an independent medical evaluation of plaintiff on January 2, 2003. He concluded that there was "no evidence [that plaintiff] would be considered disabled from a musculoskeletal standpoint."

(4) Dr. Richard Silver, an orthopedic surgeon, reviewed plaintiff's medical file at the request of defendant and concluded that plaintiff was "fit for duty at a sedentary light capacity . . . from an orthopedic perspective."

(5) Dr. Mary K Fisher is a psychologist who saw plaintiff on a referral from Dr. Melby to evaluate plaintiff's complaints of memory loss, headaches, and cognitive difficulties. She conducted psychological tests on plaintiff, found him "to suffer from deficits in executive functioning including sequencing, planning, mental organization, and metal [sic] control." She also diagnosed him with "global memory deficits." Her conclusion was that plaintiff "meets the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury."

(6) Mary Sullivan, Ph.D., L.P., performed a neuropsychological evaluation of plaintiff on August 22, 2002 on a referral from Dr. Melby. After consideration of his medical history and testing results she noted:

> All of this background information suggested that Mr. Kobs might have presented himself in such a way as to confirm his own view of himself as memory-impaired and brain-injured. However, there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout this evaluation.

She concluded that there was no evidence that plaintiff had sustained a closed head injury and that plaintiff was not "cognitively disabled or memory impaired."

(7) Dr. Reginald Givens is a psychiatrist and neurologist hired by defendant to review plaintiff's file. He concluded "according to objective evidence in the medical records, Mr. Kobs does not have a significant impairment that would impair him from performing essential functions of his employment. There are no specific limitations regarding ability to function relating to Mr. Kobs' impairments."

(8) Philip Sarff, is a psychologist employed by defendant to conduct an independent psychological evaluation of plaintiff and to review his medical records. He conducted an evaluation on March 27, 2003 and concluded that plaintiff's "pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury. Unfortunately, there is strong evidence that he consciously or unconsciously exaggerated symptoms for this evaluation."

(9) Francine Blaha, R.N. reviewed plaintiff's medical records at defendant's request on August 17, 2003. She recommended: "Based on the objective medical documentation provided for review, the objective data does not even come close to the massive subjective complaints of the claimant. Uphold denial."

MEMORANDUM

Summary judgment is appropriate when, after both parties have the opportunity to submit evidence in support of their respective positions and the Court has reviewed such evidence in the light most favorable to the nonmovant, there remains no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

A fact is material only if it might affect the outcome of the suit under the governing law. Disputes over unnecessary or irrelevant facts will not preclude summary judgment. A factual issue is genuine only if the evidence is such that a reasonable factfinder, applying the appropriate evidentiary standard of proof, could return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 254 (1986).

Plaintiff seeks long-term disability (LTD) benefits allegedly due under an employee benefit plan governed by ERISA, 29 U.S.C. § 1132(a)(1)(B). The LTD plan provides that "[b]enefits under this policy will be paid only if United Wisconsin Insurance Company decides in its discretion that the Insured is entitled to them." This language gives the administrator discretion to determine plaintiff's eligibility for benefits under the plan. *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000). Accordingly, the Court reviews plaintiff's determination under an "arbitrary and capricious" standard of review. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Under the "arbitrary and capricious" standard it is not the Court's function to decide whether it would have reached the same conclusion or relied on the same authority. *Carr v. Gates Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999) (citing *Cvelbar v. CBI Ill. Inc.*, 106 F.3d 1368, 1379 (7th Cir. 1997)). "[T]he administrator's decision will only be overturned if it is 'downright unreasonable.'" *Id.*

The presence of an apparent conflict of interest is a factor to be weighed when deciding whether an administrator's decision was arbitrary and capricious. *O'Reilly v. Hartford Life & Accident Ins. Co.*, 272 F.3d 955, 960 (7th Cir. 2001) (citing *Firestone*, 489 U.S. at 115). Plaintiff argues that heightened scrutiny is warranted in the form of either de novo review or a "sliding scale" approach to "arbitrary and capricious" review, *see Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987), because defendant acted as both plan administrator and insurer in denying plaintiff's claim. If the first-level decisionmaker has an interest in the outcome, this potential for bias is bound to affect the mind set of the reviewing court." *Perlman v. Swiss Bank Comprehensive*

Disability Protection Plan, 195 F.3d 975, 981 (7th Cir. 1999).

More recently however, the Seventh Circuit has observed that conflict of interest concerns are minimal in the typical insurance context. "Most insurers are well diversified, so that the decision in any one case has no perceptible effect on the bottom line. There is correspondingly slight reason to suspect that they will bend the rules." *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 408-409 (7th Cir. 2004). Further, "it is unsound for the judiciary to automatically impute the plan administrator's position to the person who decides on its behalf." *Perlman*, 195 F.3d at 980-81. "Unless an insurer or plan administrator pays its staff more for denying claims than for granting them, the people who actually implement these systems are impartial." *Leipzig*, 362 F.3d at 409. Accordingly, there is little basis to diverge from the arbitrary and capricious standard of review.

Based on the record before it, the administrators denial was reasonable, amply supported by extensive medical records and not arbitrary and capricious. The medical evidence was in near unanimous support of the conclusion that plaintiff was not disabled as a result of any orthopedic conditions. Based on Plaintiff's brief it appears that he does not pursue a contrary position arguing only that reduced cognitive abilities and dementia rendered him disabled. However, the overwhelming weight of the medical evidence – and particularly the conclusions of Dr. Sullivan who was independent and not hired by defendant – suggested that plaintiff's complaints were exaggerated and that he did not have significant cognitive impairment. Defendant was not obligated to blindly accept the testimony of plaintiff's personal physician and the single

psychological expert who supported his position and ignore the numerous opinions to the contrary. Weighing all of the testimony it was entirely reasonable to conclude that plaintiff had no significant mental impairment and was therefore not disabled within the meaning of the plan.

Plaintiff argues that defendant's decision to deny his claim was arbitrary and capricious because the administrative record does not suggest any material change in plaintiff's medical condition from when he was determined to be "totally disabled" under the short-term disability plan and when he was determined not to be "totally disabled" under nearly identical language in the LTD plan:

> If Mr. Kobs made a miraculous recovery on July 4th 2002 (the day short-term benefits expired) there is nothing in the record indicating so. Absent such a medical finding there is absolutely no support for UWIC's conclusion that Mr. Kobs did not qualify for long terms [sic] benefits the first day he was eligible.

Plaintiff's argument is unpersuasive. Defendant's exercise of its discretion to pay plaintiff short-term disability benefits is not an admission that plaintiff was "totally disabled" within the meaning of the short-term disability policy. Moreover, even if defendant had believed that plaintiff was "totally disabled" under the short-term policy, defendant's thorough review of plaintiff's medical documentation – not a belief that plaintiff had made a "miraculous recovery" – was sufficient to dispel such a belief as to the long-term policy.

Finally, plaintiff argues that the administrative record contains no evidence that the experts who opined that he was not disabled considered the material duties of plaintiff's

occupation when it made that determination. Plaintiff's argument fails on two levels. First, most of the experts concluded that plaintiff lacked any significant cognitive impairment. Accordingly, a non-disabled conclusion would follow regardless of particular knowledge of the job duties. Second, it is apparent from a reading of the record that the experts were well aware generally of the mental abilities required to perform the types of tasks associated with plaintiff's position as a car dealership business manager.

Defendant's denial of plaintiff's claim was reasonable and not arbitrary and capricious. Accordingly,

ORDER

IT IS ORDERED that defendant United Wisconsin Insurance Company's motion for summary judgment is GRANTED.

IT IS FURTHER ORDERED that judgment is entered in favor of defendant against plaintiff Elvis Kobs dismissing plaintiff's complaint and all claims contained therein with prejudice and costs.

Entered this ~~22nd~~ 28th day of May, 2004.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS,

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Defendant.

ORDER
04-C-005-S

* * *

ORDER

IT IS ORDERED that defendant's motion for protective order is GRANTED; the court being of the opinion that a deposition is not required to determine the administration [sic] record in this matter.

IT IS FURTHER ORDERED that plaintiff's second motion for enlargement of time is PARTIALLY GRANTED.

IT IS FURTHER ORDERED that plaintiff may serve and file not later than noon, May 12, 2004 a response to defendant's motion for summary judgment addressing the concerns he has pursuant to Rule 56, Federal Rules of Civil Procedure.

IT IS FURTHER ORDERED that defendant may serve and file a reply not later than noon, May 21, 2004.

Entered this 5th day of May, 2004.

BY THE COURT:

/s/ John C. Shabaz
JOHN C. SHABAZ
District Judge

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

April 26, 2005

Before

Hon. Joel M. Flaum, *Chief Judge*

Hon. William J. Bauer, *Circuit Judge*

Hon. Michael S. Kanne, *Circuit Judge*

No. 04-2483

Elvis Kobs,
Plaintiff-Appellant,

v.

United Wisconsin Insurance Company,
Defendant-Appellee.

Appeal from the United States District Court for the Western District of Wisconsin.

Case No. 04 C 5

John C. Shabaz, *Judge.*

ORDER

On consideration of the petition for rehearing and petition for rehearing *en banc*, both filed on March 30, 2005 by the plaintiff-appellant in the above-captioned case, no judge in active service has requested a vote on the petition for rehearing *en banc* and all of the judges on the original panel have voted to deny rehearing. It is, therefore, ordered that rehearing and rehearing *en banc* are DENIED.

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

DECISION

IN THE CASE OF	**CLAIM FOR**
	Period of Disability, Disability Insurance Benefits, and
Elvis K. Kobs	Supplemental Security Income
(Claimant)	
	387-50-4896
(Wage Earner)	(Social Security Number)

PROCEDURAL HISTORY

The claimant, Elvis Kobs, protectively filed the current applications for disability insurance benefits and supplemental security income on May 29, 2002, alleging disability as of January 3, 2002. His claims were denied initially and upon reconsideration, and a request for hearing was timely filed on December 15, 2003. A hearing was subsequently held on December 15, 2004 in Eau Claire, Wisconsin. The claimant appeared and testified, and was represented by Jason Whitley, an Attorney-at-Law. Donna Kobs, the claimant's wife, appeared and testified on his behalf. Michael Lace, Psy.D., appeared and testified as the neutral medical expert. Sidney Bauer, M.S., the neutral vocational expert, appeared but was not called upon to testify. The undersigned has considered the evidence of record before her and all arguments presented.

ISSUES

The general issue presented by the claims is whether the claimant is entitled to a period of disability and disability

insurance benefits under sections 216(i) and 223, respectively, of the Social Security Act; and whether the claimant is disabled under section 1614(a)(3)(A) of the Act. The specific issues are whether the claimant is under a disability as defined by the Act, and, if so, when such disability commenced and the duration thereof; and whether the disability insured status requirements of the Act are met for the purpose of entitlement to a period of disability and disability insurance benefits.

EVALUATION OF THE EVIDENCE

After carefully considering all of the evidence and testimony of record, the undersigned concludes that the claimant may be found to be under a statutory disability since January 3, 2002, the date he asserted he became disabled, based on his mental impairments, in combination, medically equaling the requirements of sections 12.02, organic mental disorder, 12.04, affective disorder, and 12.07, somatoform disorder, of the Listing of Impairments.

The claimant met the insured status requirements for entitlement to Title II benefits on January 3, 2002, the disability onset date, and continues to meet those requirements through the date of this decision. (Exhibit 4D)

The claimant has not engaged in substantial gainful activity since April 2, 2002, the disability onset date. The record and testimony at hearing indicate that the claimant attempted to resume work after April 2, 2002. He reported that about mid-2003, he went to work as a mortgage loan officer for a mortgage company in New Richmond. He was asked to resign from the position after three months because of poor organization and his need to re-ask a lot of questions. There is no indication in the record that this

activity resulted in earnings at a level considered presumptive of substantial gainful activity. 20 C.F.R. §404.1574(b) and §416.974(b). Thus, the claimant's applications for benefits may not be denied because of substantial gainful activity. (Exhibits 4D, 8E and 2E) The record reveals that the claimant has at least one severe impairment.

The evidence of record establishes that the claimant is subject to mental impairments under section 12.02, organic mental disorder, section 12.04, affective disorder, and section 12.07, somatoform disorder. Thus, the regulations require the undersigned to conduct the sequential evaluation within the provisions of 20 C.F.R. §404.1520a and §416.920a, which include additional analysis and evaluation as amended on September 20, 2000.

The undersigned finds that the claimant is severely impaired by an adjustment disorder with depression and anxiety features, an organic mental disorder secondary to a trauma, and a conversion disorder.

At the hearing, Michael Lace, Psy.D., the neutral medical expert, who specializes in Clinical Psychology, testified that the claimant's mental impairments, in combination, medically equal the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairments. Dr. Lace related that the record shows that the claimant struggles with an affective disorder, a depression disorder, not otherwise specified, and diminished mental capabilities due to a head injury. Dr. Lace indicated that the claimant tends to turn stress into physical symptoms, and he has no insights into his problems. The undersigned concurs with Dr. Lace's assessment of the claimant's mental functioning because it is fully supported by the evidence of record. The undersigned finds that the claimant's combination of

ments of section 12.02, 12.04 and 12.07 of the Listing of Impairments as of January 3, 2002. The undersigned further finds that these mental impairments, in combination, has [sic] resulted in mild restriction of activities of daily living, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, and no episodes of decompensation.

The claimant credibility [sic] testified that he is married and living with his wife. He does the dishes and some cooking, and vacuums on occasion. The claimant indicated that he used to fish and hunt, but no longer engages in these hobbies. He has no social life except for visits with his children and grand children. The claimant stated that he has a driver's license, but only drives once or twice a week. He only drives to grocery stores and physician appointments, but at times, would get confused while driving. The claimant related he was asked to resign from his job as a mortgage loan officer because of poor organization and his need to re-ask a lot of questions. He has problems concentrating, and he forgets what he reads. The claimant stated that he used to do the book keeping [sic] and handle the finances; however, he could no longer perform these duties because he would "goof" everything up. Thus, his wife is now responsible for them. The claimant reported that he is depressed and needs to take medication once a day.

Mrs. Kobs testified that her husband has a poor memory. Her husband would lock his keys in the car, get lost, and forget what he has been told after one hour. Mrs. Kobs related that one time her husband went to the pharmacy and did not remember how to get home. When her husband goes for a walk, he has to be watched; thus, someone is always with her husband. Mrs. Kobs stated that her

husband believes that he is right but is always wrong. He [sic] husband started their new home on fire once when he forgot that he was making an egg sandwich and went to sleep.

A discharge summary dated January 11, 2002, revealed that the claimant was hospitalized for 7 days for falling off the roof of his house. On April 12, 2002, the claimant presented for a neurological consultation of his short-term memory loss. He reported his memory was poor, and he could not remember common things that happened throughout the day and week. He related that a few years ago, he hit his head on a metal cabinet while at work, and he has been treated for depression for five years since his wife was diagnosed with cancer. The claimant indicated that he was taking Paxil. John Floberg, M.D., the evaluating neurologist, stated that the claimant's exam showed some impairment on mental status testing especially for short term memory. Dr. Floberg's assessments were of short-term memory loss, minor closed head injury, and depression. (Exhibits 5F and 7F)

A neuropsychological evaluation on August 22, 2002 by Mary Sullivan, Ph.D., L.P., a licensed psychologist, revealed that the claimant's test results were not consistent with the presence of memory problems secondary to a closed head injury. Dr. Sullivan indicated that although an absence of progressive memory loss should be good news, it probably would not be greeted with much enthusiasm. There was evidence of a tendency to convert stress reactions to physical symptoms, and to be unaware of underlying psychological conflicts or concerns. Dr. Sullivan related that the claimant was experiencing more psychological distress than he was willing to acknowledge. With regard to his ability to return to work, Dr. Sullivan stated that

the claimant had some psychological disturbance which would render it difficult for him to be a fully engaged worker. The claimant saw himself as too sick to work, and he was sincerely convinced of this view, which had been reinforced by his family. (Exhibit 12F)

On November 22, 2002, MaryKay Fisher, Psy.D., evaluated the claimant's cognitive and memory functioning, at the request of his primary care physician. Dr. Fisher stated that the claimant complained of short-term memory impairment, difficulty with comprehension of new material, concentration deficits, sad/worried mood, irritability, decreased frustration tolerance, cognitive slowing, trouble with planning/sequencing/organization, poor mental control, and constant headaches. Dr. Fisher reported that on mental status examination, the claimant was very talkative, and he had a tendency to confabulate, which appeared to be a defensive response to his inability to access memories or information. The claimant was very invested in doing well on the testing, despite it [sic] stated purpose being to document deficits. Dr. Fisher wrote that the claimant's mood was sad and worried, and his affect was dysthymic and of mild intensity and constricted range. His interpersonal good cheer appeared rather forced, and he acknowledged excessive worry, tension, and irritability. Dr. Fisher related that the claimant's sleep and appetite were impaired, and he had difficulty concentrating. He could not watch a television show through to the end, or finish a computer game. Dr. Fisher indicated that he read very slowly, forgetting what he read, and had difficulty with comprehension. His cognitive processing appeared slow. Dr. Fisher related that his narrative stream was halting, and it was apparent that he had retrieval difficulties. His processing was so slow that he

would occasionally lose track of the task, and he had to work very hard to accomplish a mental task and the effort involved was exhausting. Dr. Fisher stated that attention/concentration per se was not the deficiency, rather mental stamina, speed, and control were the areas of greatest impairment. Dr. Fisher concluded that the claimant had dementia due to a head trauma, an adjustment disorder with depression and anxiety, and a head injury. In an accompany functional capacities evaluation/mental abilities and aptitudes form, Dr. Fisher rated the claimant as "limited ability or unable to perform" in most areas under the heading of Understanding, Carrying Out, and Remembering Instruction given at the start of an 8-hour day, during the course of the day; in all areas under the heading of Use of Judgment; and in the area of ability to respond appropriately to changes in a routine work setting under the heading of Dealing with Changes in Routine Work Setting. (Exhibit 14F)

On December 5, 2002, Neal Melby, M.D., the claimant's primary care physician, stated that the claimant had developed a memory deficit, and he and his wife were very frightened by these ongoing problems. The claimant had tried to work as a loan counselor and mortgage office [sic], but was unable to intellectually perform the duties of this job. Dr. Melby further stated that the claimant's findings appeared to be progressive and had led to a great deal of anxiety and depression. Dr. Melby was concerned regarding some potential for suicide. Dr. Melby opined that the claimant was disabled and unemployable. (Exhibit 15F)

On March 21, 2003, Dr. Melby opined that the claimant was capable of less than a full range of sedentary exertional work, with low tolerance for frustration; difficulty communicating his needs; difficulty following instructions;

difficulty engaging in complex tasks that required judgment; difficulty with decision making; difficulty following through on agreed actions; difficulty working around other people; difficulty controlling anger appropriately; socially inappropriate responses to situations; inability to work with children; difficulty with reality interpretation; difficulty being in unfamiliar environments; panic attacks; and difficulty with impulse control. (Exhibit 20F)

A psychological report dated November 13, 2003 by Travis Hinze, Ph.D., a licensed psychologist, at the request of the Social Security Administration, revealed that the claimant's overall current level of intellectual function was in the low average range. Dr. Hinze's impression was of depressive disorder, not otherwise specified, by history. Dr. Hinze stated that based on his evaluation, he was unable to determine the claimant's capability for work capacity or ability to manage funds. (Exhibit 16F)

A review of the overall evidence leads the undersigned to conclude that there are at least two ratings at the degree of severity that satisfies the requirements of the Listing of Impairments. As noted above, Dr. Lace, the neutral medical expert, is also of the opinion that the claimant's mental impairments, in combination, have reached the degree of severity, which satisfied the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairments. Accordingly, the undersigned finds that the claimant's mental impairments, in combination, have medically equaled the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairment since January 3, 2002. Although there are indications in the record of severe physical impairments, the undersigned finds that further analysis of these conditions is unnecessary since the

claimant has already been found disabled on the basis of his combination of mental impairments.

The undersigned has considered the opinions and assessments rendered by Disability Determination Services' examining and consulting physicians in accordance with Social Security Ruling 96-6p. The undersigned declined to adopt these opinions and assessments in light of the significant new evidence received since those opinions were rendered. Greater weight is given to the opinions and assessments of Dr. Melby, the claimant's treating physician, Dr. Fisher and Dr. Sullivan, consultative psychologists, and Dr. Lace, the neutral medical expert, on the issue of the claimant's mental functioning because of the opportunity they had to review current treatment records. As a result, the claimant is determined to be disabled at all time since January 3, 2002.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant met the insured status requirements for entitlement to Title II benefits at all times relevant herein.

2. The claimant has not engaged in substantial gainful activity since January 3, 2002, the disability onset date.

3. The claimant is severely impaired by an adjustment disorder with depression and anxiety features, an organic mental disorder secondary to a trauma, and a conversion disorder.

4. The medical evidence establishes that the claimant's mental impairments, in combination, medically equaled the requirements of sections 12.02, 12.04, and 12.07 of the Listing of Impairments, Part 404, Subpart P, Appendix 1.

5. The claimant has been under a disability, as defined in the Social Security Act, since January 3, 2002. 20 C.F.R. §404.1520(f) and §416.920(f).

DECISION

It is the decision of the Administrative Law Judge that, based on the applications protectively filed on May 29, 2002, the claimant has been disabled since January 3, 2002 under sections 216(i) and 223(a), respectively, of the Social Security Act, and sections 1602 and 1614(a)(3)(A), respectively, of the Act.

The component of the Social Security Administration responsible for authorizing supplemental security income payments will advise the claimant regarding the nondisability requirements of these payments, and if eligible, the amount and month(s) for which payment will be made.

/s/ Paul D. Tierney
Paul D. Tierney
Administrative Law Judge

APR 21 2005
Date

LONG TERM DISABILITY
GROUP INSURANCE POLICY

POLICYHOLDER: Bernard's Northtown, Inc.

POLICY NUMBER: 0702273 0000

POLICY EFFECTIVE DATE IS 12:01 A.M.: July 15, 2001

POLICY RENEWAL DATE: August 1, 2002

STATE OF ISSUE: Wisconsin

PREMIUM DUE DATE: 1st day of the coverage month

This group insurance policy is issued to the Policyholder named above, in the state specified, and to the extent that it is governed by state law, the laws of that state will control.

Risk assumed under this policy will be insured from the effective date of this policy, subject to all policy provisions.

The initial term of this policy is the period specified within. However, if this policy is issued as a restatement of the risk assumed by any prior policy issued by United Wisconsin Insurance Company, then, subsequent revision of coverage or premium rate notwithstanding, the initial policy term specified will be deemed to have occurred under that prior policy.

All of the following articles, schedules, and amendments are part of this policy and available benefits are dependent upon them. Altogether this policy is issued on Our authority.

United Wisconsin Insurance Company

_____

President

The Policyholder agrees to all the terms of this policy.

* * *

SECTION I

POLICY OUTLINE

LONG TERM DISABILITY BENEFIT PLAN

BENEFITS:

_____ Class _____

Number	Description	Elimination Period
01	All Actively at Work Full-Time Employees	180 days

Benefit Percentage: 66_% of Pre-Disability Earnings, not to exceed the maximum monthly Benefit. ***NOTE:*** This amount is subject to reductions as specified in Section IV, Benefit Administration.

Maximum Monthly Benefit: $6,000

Minimum Monthly Benefit: The greater of: 1) $100.00; or 2) 10% of the monthly Benefit before deductions for Other Income Benefits. Applies to Total Disability Benefits only.

Maximum Benefit Period: See Section IV, Benefit Administration, Length of Payment.

ELIGIBILITY REQUIREMENTS:

Full Time: 30 hours per week

Service Waiting Period: 90 days; however, eligibility for coverage will be effective on the first of the month coinciding with or following completion of the Service Waiting Period.

Minimum Participation: 10 persons; or
100% of the persons eligible for non-contributory insurance; or

75% of the persons eligible for contributory insurance

PREMIUM RATE: $0.28 per $100 Covered Payroll

INITIAL RATE GUARANTEE PERIOD: 24½ months

CONTRIBUTION: 100% of the premium charges are paid by the Insured.

AMENDMENTS: None

* * *

DEFINITION OF LONG TERM DISABILITY

"TOTAL DISABILITY" and **"TOTALLY DISABLED"** means that due to Injury and/or Illness,:

1. the Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the Benefit Period; and

2. after 24 months of the Benefit Period, the Insured cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training or experience.

"PARTIAL DISABILITY" and "PARTIALLY DISABLED" means that due to Injury and/or Illness, the Insured is unable to earn 80% of his or her monthly Indexed Pre-Disability Earnings because of that Injury or Illness and is either:

1. during the first 24 months of the Benefit Period, unable to perform all material duties of his or her regular occupation on a Full-Time basis, but is performing at least one of the material duties

of his or her regular occupation or another occupation on a part-time or Full-Time basis; or

2. after the first 24 months of the Benefit Period, unable to perform the material duties of any occupation for which he or she is or may be reasonably fitted by education, training or experience.

When Totally or Partially Disabled based on objective medical findings, the Insured must be under the Regular Care and Treatment of a Physician and provide documentation of same as required by Us. The Insured may be required to see a Physician selected by Us for an independent medical examination.

* * *

SECTION IV

BENEFIT ADMINISTRATION

BENEFIT DETERMINATION

Benefits under this policy will be paid only if United Wisconsin Insurance Company decides in its discretion that the Insured is entitled to them.

BENEFIT PAYMENT

The Elimination Period must be satisfied while the Insured is Totally Disabled and proof of loss and proof of earnings must be received by Us before Benefits become payable. Refer to the Proof of Loss provision under the General Provisions section of this policy.

If the Insured recovers from a Total Disability during the Elimination Period and returns to Full-Time, Active Work and is Disabled again later, the Elimination Period will be

considered continuous if the work period does not exceed a total of 5 days for every 30 days of the Elimination Period.

Any day the Insured is working between periods of Total Disability will not be counted in the total days required to satisfy the specified Elimination Period. If after a return to Full-Time, Active Work an Insured becomes eligible for or covered under any other group long term disability plan, this paragraph will not apply.

The Insured will qualify for continuing Benefits as long as he/she remains Disabled and requires the Regular Care and Treatment of a Physician. But, We will not pay any longer than the maximum Benefit Period shown in the Policy Outline and the Length of Payment provision.

AMOUNT OF BENEFIT

The monthly Total Disability Benefit will be an amount equal to:

1. a percentage of the Insured's Pre-Disability Earnings up to a maximum Benefit as indicated on the Policy Outline less Other Income Benefits (as defined later in this section); but

2. not less than the minimum Benefit, except in the case of overpayment or while receiving work earnings.

* * *

OTHER INCOME BENEFITS

Other Income Benefits means those benefits for which the Insured is entitled to, whether applied for or not, or receives from any of the sources listed below which will be used to equally reduce the Disability Benefit.

1. The amount for which the Insured is eligible under:
   a. Workers' or Workmen's Compensation Law;
   b. occupational disease law; or
   c. any other act or law of like intent.
2. The amount of any disability income benefits for which the Insured is eligible under:
   a. any other group insurance plan; or
   b. any governmental retirement system.
3. The amount of any disability income benefits for which the Insured is eligible under any compulsory benefit act or law.
4. The amount of disability benefits and/or Retirement Benefits the Insured receives under his or her employer's retirement plan.
5. The amount of employer or Policyholder sponsored salary continuation or sick leave pay.
6. The amount of disability or Retirement Benefits the Insured is eligible for under the United States Social Security Act, or any similar statute of any state or country.
7. The amount of disability or Retirement Benefits the Insured's family is eligible for under the United States Social Security Act, or any similar statute of any state or country.

These Other Income Benefits, except Retirement Benefits, must be payable as a result of the same Disability for which We pay a Benefit.

We may estimate Other Income Benefits and reduce the Disability Benefit if:

1. for Social Security benefits, there is a failure to pursue benefits in a timely manner until denied at the Administrative Law Judge level; and/or

2. for all other benefits listed, it is reasonable to believe that had the Insured applied for the benefit within the required time period, it would have been paid.

After the initial reduction of the monthly Disability Benefit by Other Income Benefits, no additional reduction will be made for subsequent cost of living adjustments to such Other Income Benefit payments.

ADJUSTMENTS AND CHANGES IN BENEFIT

When Disability Benefits are adjusted:

1. whenever Benefit amounts have been underpaid, We will pay the amount necessary to adjust Benefits already paid and adjust current and future Benefits; and

2. whenever Benefit payments have been made in excess of the payment allowed under the policy, the excess payment amount is due and payable to Us by the Insured. We will reduce future Benefit amounts that remain payable if necessary, to recover the overpayment.

Changes in the amount of Benefits payable due to coverage changes will apply:

1. from the effective date of the change; and
2. only to Insureds Actively at Work on or after the effective date of the change; and
3. only after We have approved Evidence of Insurability, if required.

LENGTH OF PAYMENT

The maximum Benefit Period for the Insured Disabled before attainment of age 60 extends until attainment of age 65 subject to the Limitations and Exclusions provision.

The maximum Benefit Period for the Insured Disabled after attainment of age 60 extends until the expiration of the Benefit Period specified in the table below subject to the Limitations and Exclusions provision:

Benefit Duration	
Age at Disability	Benefit Period Limit
61 or younger	To age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

TERMINATION OF BENEFITS

Disability Benefits will cease on the earliest of:

1. the date the Insured is no longer Disabled as defined in this policy; or
2. the date the Insured is no longer under the Regular Care and Treatment of a Physician for the disabling condition; or
3. the date the Insured returns to Full-Time, Active Work unless such work is part of Rehabilitation which has been approved by Us; or
4. the date the Insured dies, unless Survivor Benefits are payable; or
5. the end of the maximum Benefit Period; or
6. the date the Insured's work earnings equal or exceed 80% of his or her Pre-Disability Earnings; or
7. the date the Insured fails to cooperate in Rehabilitation; or
8. the date the Insured fails to submit to an Independent Medical Examination; or
9. the date the Group fails to make reasonable accommodations as defined under the Americans with Disabilities Act.

* * *

NONPARTICIPATING POLICY

This policy is non-participating. It will not receive any distribution from Our surplus earnings, if any; nor will it be assessable to recover loss, if any, to Our equity.

SECTION VII

GENERAL PROVISIONS

ENTIRE CONTRACT AND CHANGES

This policy, including all provisions, schedules, outlines, endorsements and amendments, the application of the Group or Policyholder and the individual applications of the Insureds, and Evidence of insurability, if applicable, constitute the entire contract between the Group or Policyholder and Us. No change in this policy will be valid unless approved in writing by one of Our executive officers and attached to this policy. No agent has authority to change this policy, or to waive any of its provisions.

LEGAL ACTIONS

No action at law or in equity may be brought to recover on this policy prior to the expiration of a 60 day period from the date that written proof of loss has been furnished to Us. No action at law or in equity may be brought after the expiration of a 3 year period commencing from the time proof of loss is required to be provided to Us by the Insured.

Solely at Our discretion, We may elect to use the mediation or binding arbitration procedures of the American Arbitration Association to settle a dispute. Such procedures shall follow the Association's Commercial Rules, and take place in Milwaukee, Wisconsin.

STATEMENTS BY THE GROUP OR INSUREDS

A statement made by the Group or an Insured under this policy will not be used in any legal contest unless a copy of

the instrument containing the statement is or has been furnished to that Group, Insured, or other party to such a contest.

A statement made by the Group or by an Insured will be deemed a representation and not a warranty. A written statement made by the Group or an Insured will not be used as a defense to a claim or to void or reform coverage unless the statement is signed by the Group or Insured, and a copy of the statement is or has been furnished to that Group, or the Insured.

TIME LIMIT ON CERTAIN DEFENSES

Except for fraudulent statements, no statement made by any Insured under this policy relating to that Insured's coverage will be used to contest the validity of the coverage extended to that Insured after the coverage had been in force for a period of 2 years.

NOTICE OF CLAIM

Written notice of claim must be given to Us within 30 days of the Date of Loss or as soon thereafter as it is reasonably possible to give such notice. Notice given by or on behalf of the Insured or their beneficiary to Us at Our home office, P.O. Box 2013, Milwaukee, WI 53201-2013, with sufficient information to identify the Insured, shall constitute notice of claim.

Upon receipt of that notice We will send claim forms to the Insured. If claim forms are not received by the Insured within 15 days of the notice of claim, then the Insured will be in compliance with the requirements of proof of loss when verifiable documentation is received by Us that

establishes the eligibility of the Insured, the date and cause of the Insured's disablement, and the Physician(s) treating the insured for Disability.

PROOF OF LOSS

1. The proof must provide:
   a. the Date of Disability; and
   b. objective medical evidence (the Insured must cooperate in obtaining the medical information); and
   c. dates and type of treatment; and
   d. certification of Total or Partial Disability; and
   e. standard nomenclature diagnosis.
2. Proof of loss must be given to Us within 90 days of the Date of Disability; except, if it is not possible to give proof of loss within 90 days from the Date of Disability, it may be given as soon thereafter as reasonably possible as long as proof of loss is provided within one year and 90 days and We have not been prejudiced by the delay. If We do not receive proof of loss within these required time limits, We will deny the claim. These limits will not apply during periods of Disability or Partial Disability where the insured lacks legal capacity. These time limits will resume once legal capacity is regained.
3. Proof of continued Disability or Partial Disability and Regular Care and Treatment of a Physician must be given to Us within 30 days of the request for the proof. If it is not possible to give proof of continued Disability or Partial Disability

and Regular Care and Treatment of a Physician within 30 days of request, it may be given as soon thereafter as reasonably possible as long as We have not been prejudiced by the delay.

TIMELY PAYMENT OF CLAIMS

Claims incurred while this policy is in force will be paid upon receipt and validation of due written proof of loss. For any loss for which periodic Benefits are payable, We will pay the Benefits at the end of each month, or lesser period, for which We are liable after We receive the required proof. Any balance unpaid when Total or Partial Disability ends will be paid after We receive the required proof.

TO WHOM PAYABLE

Benefits will be paid to the Insured. If any accrued Benefits are payable to either an Insured who is not competent to give a valid release and no guardian or conservator has been appointed by the courts, or to an Eligible Survivor who is a minor or otherwise not competent to give a valid release, We may pay up to a maximum of $1,000 to any one or more surviving relatives We determine are equitably entitled to payment.

If the Insured is deceased and accrued Benefits are payable, We will pay those Benefits to the Eligible Survivor or the Insured's estate.

Any amount We pay in good faith releases Us from further liability for the amount paid.

CLAIM APPEAL

An employee has the right to appeal Our decision regarding any denial of all or any part of a Disability or Partial Disability Claim. The employee must request an appeal within 60 days of receiving Disability or Partial Disability Benefit denial notification.

The request for an appeal must contain the employee's name, identification number and reason for requesting the review. We will review the claim after We receive the request. We will send a notice of Our decision and reasons therefore within 60 days after receiving the request. However, if special circumstances require an extensive review, We will make Our final decision within 120 days of receiving the request.

* * *

CONFORMITY WITH STATE STATUTES

Any provision of this policy that, on its effective date, is in conflict with the statutes of the state in which it is issued, or issued for delivery, is amended by this section to conform to the minimum requirements of that state statute.

SEVERABILITY

Any provision of this policy which may be prohibited by law, will be and will become without force or effect within that jurisdiction; however, the void provision will neither invalidate nor impair the enforceability of any other provision of this policy.

BENEFIT ASSIGNMENT

Benefits under this policy are assignable.

PHYSICAL AND/OR VOCATIONAL EXAMINATION

We may have the Insured examined by a Physician or vocational expert of Our choice when and as often as We may reasonably require. The Insured must cooperate with the examination in order to substantiate proof of loss or continued proof of loss. We will bear the cost of the examination. We reserve the right to withhold or stop Benefits when the Insured fails to submit to a medical exam We schedule.

* * *

[LOGO] United Wisconsin Group

Post Office Box 2013
Milwaukee, Wisconsin 53201-2013
262/787-7400
800/452-4250
Fax 262/787-7575

RAPID PAY INCOME REPLACEMENT PLAN – EMPLOYEE CLAIM FORM

PROMPT SUBMISSION AND COMPLETE INFORMATION ARE NECESSARY FOR THE NON-INTERRUPTION OF YOUR INCOME.

TO BE COMPLETED BY EMPLOYEE

Employee Name	Sex	Date of Birth	Weight	Height	Social Security Number
Elvis Kevin Kobs	M ☒ F ☐	01-25-51			387-50-4896

Mailing Address	City	State	Zip Code	Home Phone
65 County Road M	Star Prairie	WI	54026	715-248-7984

Company Name	Work Address	Work Phone
Bernards Northtown Inc.	510 Deere Dr., New Richmond WI 54017	715-246-2236

Is this disability the result of an accident?	Date	Time	Place
☒ Yes ☐ No	1-4-02	☐ am ☒ pm 12:30	☒ Home ☐ Work ☐

Please describe: Fell off roof while taking down Santa, Sleigh & Reindeer

* * *

EMPLOYMENT STATUS AND SALARY INFORMATION

Employer (Policyholder)	Group/Division No.	Plan Effective Date
Bernards Northtown Inc.	0702273 0000	07/15/01

Group Name	Group Address	City	State	Zip
Bernards Northtown Inc.	510 Deere Drive,	New Richmond	WI	54017

Date of Hire	Effective Date of Coverage	Date Last Worked	How many Hours Worked On Last Day Of Work	Actual Day Returned To Work:
~~7 94~~ ~~03/25/51~~	07/15/01	01/03/02	10 Hours	unknown / /

Employee Status on Last Day Worked
(Give effective date where indicated.)

☑ Active ☐ Personal Leave ☐ Family/Medical Leave
☐ Laid Off ☐ Retired ☐ Terminated
Effective Date: ___ / ___ / ___

Earnings $1637.68
☐ Hourly ☒ Weekly ☐ Bi-weekly ☐ Monthly
☐ Semi-Monthly Earnings Effective Date: 01 / 01 / 01

Benefit Class: ☐ Salaried Exempt ☐ Salaried Non-exempt
☐ Hourly ☐ Union ☐ Other _____

Regular Work Week and Hours Per Day: Mon. 9.0
Tues. 8.0 Wed. 11.0 Thur. 9.0 Fri. ___ Sat. 9.0 Sun. ___

Benefits: Flat weekly benefit amount: $___ OR ___% of salary
Maximum amount: $_____

Percent of premium paid by employer
(based on 3 year average) 6.0%;

Is employee's contribution from pre-tax wages? ☐ Yes ☒ No

Other Benefits:	Sick Pay/ Salary Cont.	$ 0	per week, effective from ___ through ___
	Workers' Compensation	$ 0	per week, effective from ___ through ___
Other (specify)	_____	$ _	per week, effective from ___ through ___

Job Title: Business Manager

Classification: ☒ Sedentary ☐ Light ☐ Medium ☐ Heavy

Physical Requirements of Job: Stands 20% of day; Sits 80% of day; Bends 50 or more times/hour

Lifts 5 lbs. every ?; Carries – lbs. distance ___ frequency ___

Would modified duty be available? ☒ Yes ☐ No

If yes, please indicate type available: _____

---

* * *

[LOGO] United Wisconsin Group

P.O. Box 2013
Milwaukee, WI 53201
262-787-7400/1-800-452-4250
FAX 262-787-7575

October 22, 2002

Elvis Kobs
65 County Road M
Star Prairie WI 54026

RE: Long Term Disability – Bernard's Northtown, Inc.
SS#: 387-50-4896
Group #: 702273/0000

Dear Mr. Kobs:

We received your claim from our Short Term Disability department. We have completed our evaluation of your eligibility for Long Term Disability benefits.

The policy states:

ELIMINATION PERIOD means a series of consecutive days during which benefits are not paid, which begins with the first day of Total Disability and extends for the length of time specified in the Policy Outline (180 days)

"TOTAL DISABILITY" and "TOTALLY DISABLED" means that due to Injury and/or Illness:

1. the Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the benefit period; and

2. after 24 months of the benefit period, the Insured cannot perform any of the material duties of any gainful occupation for which

he/she is or may be reasonably fitted by education, training or experience.

"PARTIAL DISABILITY" or "PARTIALLY DISABLED" means that due to Injury and/or Illness, You are unable to earn 80% of Your monthly Indexed Pre-Disability Earnings because of that Injury or Illness and are either:

1. During the first 24 months of the Benefit Period, unable to perform all material duties of his or her regular occupation on a Full-Time basis, but is performing at least one of the material duties of his or her regular occupation or another occupation on a part-time or Full-Time basis; or

2. After the first 24 months of the Benefit Period, unable to perform at least one of the material duties of any occupation for which he or she is or may be reasonably fit education, training, or experience.

When Totally or Partially Disabled based on objective medical findings, the Insured must be under the Regular Care and Treatment of a Physician and provide documentation of same as required by Us. The Insured may be required to see a Physician selected by Us for an independent medical examination."

You became disabled on January 4, 2002. Maximum Short Term Disability benefits were paid to you through July 4, 2002.

We referred your file to an independent medical consulting group. A physician, Board Certified in Neurology and Psychiatry, reviewed the file. Based upon the review, the medical information does not support an inability to perform the duties of your occupation, after July 4, 2002.

We are unable to establish a total disability beyond the policy Elimination Period. Therefore, your claim for Long Term Disability benefits has been denied.

We regret our decision was not more favorable. The decision in this matter has been based solely upon the information contained in our file. As such, we are willing to review any additional material you wish to submit which may have an effect upon the consideration given to this claim.

We reserve all of our rights and defenses, either expressly stated or implied.

If you believe that benefits for your claim have not been administered according to the terms of the contract or your group benefit plan, you have the right to request a review of that claim. You may request this review by writing to:

United Wisconsin Insurance Company
P.O. Box 1167
Milwaukee WI 53201-1167

Your review for a request should be made within 180 days of the date of this letter and should include your name, identification and group numbers, the group name, the date your claim commenced and the reasons you believe the claim should be paid. You may ask us to review specific documents regarding your claim, and you may submit additional records, such as doctor statements for our consideration. You should also include copies of all correspondence you have received from us about your claim. We will inform you of our decision in writing within 45 days of receipt. If special circumstances require that we need more time to consider your review, you will be notified.

If you have any questions, please call this office at 1-800-452-4250.

Sincerely,

/s/ Constance Du Bose
Constance Du Bose
Claim Specialist
United Wisconsin Group

cc: Bernard's Northtown, Inc.

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

May 6, 2002

RE: Elvis Kevin Kobs
DOB: 01-25-51

To Whom It May Concern:

This patient was severely injured in a fall in January of this last year. Since then, he has been full disabled and continues to be totally disabled. The patient has severe pain in his left hip which is felt to be a referral pain from his back. He also has a fractured thumb. He did have a head injury with that fall and is in the process of being worked up for memory loss. At this point, it is felt that the patient is unemployable.

Sincerely,

/s/ Neal A. Melby
Neal A. Melby, M.D.

NAM/hkl

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

September 19, 2002

RE: Kevin Kobs
DOB: 01/25/51

Constance Du Bose
Claim Specialist
United Wisconsin Group

Dear Mrs. Du Bose,

This patient continues to be totally disabled related in part to injuries that the patient had when he fell off the roof of his house in January of 2002. The patient has injured his lower back, his knees and his left thumb. He also has reported, since that injury, increasing problems with memory loss and has cognitive impairment with his inability to do simple calculations or to remember telephone numbers including even his home phone number. The patient has had a series of workups by different specialists including back orthopedic specialists, general orthopedic specialists, neurologist specialists, psychologists and cardiology specialists as well as physical therapists. The patient's problems include a history of head injury with memory impairment and the impairment of cognitive abilities. He has degenerative disc disease of his cervical spine with chronic mechanical pain. He has multiple level degenerative disc disease of the lumbar spine with circumferential disc bulging and desiccation changes involving L3, L4 an L5 and S1. With the patient's fall from his roof, he has injured his knees and has an internal derangement of the left knee. He has also

fractured his left thumb, which has left him with residual pain and restriction of motion and loss of strength. The patient also has had chest pain and has been evaluated by a cardiology group at St. Paul Heart and Lung. He has an abnormal EKG but has not had any evidence of myocardial infarction and angiograms have revealed no significant blockage of his coronary vessels. He also has known elevated lipid levels and is under treatment for hyperlipidemia and hyperscholesterolemia. In addition, he has a long-standing hx of gastroesophageal reflux and over the last several months has become severely depressed over his lack of progress getting back to a functional status that would allow him to become employable. To date, the patient is continuing to receive therapy and is continuing to be evaluated and most recently has been at the University of Minnesota being evaluated by a psychologist specialist and is undergoing neuro psychometric testing.

In addition, he has daily severe headaches and has chronic swelling of his left lower extremity. The patient has had brain scans, which do reveal some changes within the brain substance in the area of the right frontal lobe, which shows some changes in the subcortical white matter, which may be part of the basis for his memory loss. The patient does have a remote history of head injury. For all the above listed reasons, this patient is considered to be unemployable at this time and is in need of his disability checks for his being able to pay for his number of medications related to attempting to make him comfortable and also to provide some money for his needs for basic daily living. If additional information is requested, please do not hesitate to call us at your convenience.

Sincerely,

/s/ Neal A. Melby, M.D.
Neal A. Melby, M.D.

NAM/anm

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

December 05, 2002

Mr. David Erspamer
Attorney At Law
FAX: (715) 268-7890

RE: Mr. Kevin Kobs
65 County Road M
Star Prairie, WI 54026

Dear Mr. Erspamer,

I am responding to a letter that you had sent to Mr. Kobs dated October 31, 2002 regarding his injuries resulting in his disability claims. The patient had suffered multiple injuries while employed at the Bernard's Northtown, Inc. Mr. Kobs has documented the dates of his injuries and his resultant complaints which are leading to his problems with his musculoskeletal system as well as with his central nervous system and more specifically his memory loss. The patient has undergone a second neuro psych testing and was most recently evaluated by Mary K. Fisher, Psy.D, who performed various psychological tests which have lead to several conclusions with objective abnormalities noted on psychological testings performed leading to the diagnoses as listed in her reports. I believe that Mr. Kobs is disabled and that he is disabled as a result of his injuries starting with the injuries to his back as well as to his head. He has objective evidence showing that there has been definite change from the MRI dated July of 1997 which shows the patient having an essentially negative MRI evaluation of his brain without intracranial abnormalities noted, compared to an MRI of his

brain dated 3/8/02, which definitely showed a nonspecific focus within the white matter of the right frontal lobe. In addition, the patient's lumbar spine x-rays in September of 1999 did show some mild disc space narrowing at L5 and S1 with some mild facet arthritis or facet arthropathy. A subsequent MRI of his spine did show degenerative spondylosis in L3, L4 and L4, L5 and L5, S1 with said anthropathy to L5 and S1. Subsequent MRI in April of 2002 did show disc narrowing, desiccation change and circumferential disc bulging with facet and ligamentum flavum hypertrophic changes at the levels of L3-4, L4-5 showing mild central canal stenosis and a small posterior central disc herniation at L5 and S1. These are all new changes compared to the previous MRI. It is my opinion that the patient's fall did aggravate the pre-existing condition and has led to further degenerative changes in the patient's spine. I think there is definitely a correlation between the patient's work-related injuries and his current symptoms.

With the patient's fall from his roof in January of 2002 the patient had injured his musculoskeletal system including his left shoulder area with separation of the AC joint. The patient also injured his neck leading to pain in his neck. MRI of the C-spine did show degenerative disc changes with bulging of the anulus [sic], which did appear to touch the anterior aspect of his cord but without cord deformity. This did not appear to cause any cord deformity or neural involvement. An x-ray of the patient's left hand did show a fracture of the base of his 1st metacarpal on the left. An MRI of his knee did show a posterior medial meniscus tear and joint effusion. All of these findings are consistent with injuries dating to this patient's ongoing disability.

In summary, Mr. Kobs has developed musculoskeletal problems that are leading to his inability to work. In addition, he has developed a memory deficit, which the psychologist has listed as dementia. The etiology of that is not exactly apparent to me at this time. We are recommending that the patient have further extensive neurological evaluation and recommend the Mayo Clinic for their expertise in trying to establish the etiology of this and the progression. The patient and his wife are very frightened by these ongoing problems. Mr. Kobs has tried to work as a loan counselor and mortgage officer, however he is unable to intellectually perform the duties of this job. His findings appear to be progressive and have lead to a great deal of anxiety, depression and my concern regarding some potential for suicide. These obviously are all very concerning symptoms and findings and this patient definitely is disabled from all of the above listed problems and is unemployable.

I hope this information is of use to you in attempting to being able to understand this patient's problem and disabilities. We are enclosing copies of the significant x-ray reports to further substantiate our findings.

Sincerely,

/s/ Neal A. Melby, M.D.
Neal A. Melby, M.D.

NAM/anm

Enclosure

[LOGO] **New Richmond Clinic**

A DIVISION OF
WESTERN WISCONSIN MEDICAL ASSOCIATES S.C.

April 21, 2003

RE: E. Kevin Kobs
Date of Birth: 1-25-51

To Whom It May Concern:

Both Mr. and Mrs. Kobs are chronically disabled and are unable to pursue gainful employment. They both have rather significant medical conditions which do require transportation to their treating facilities, that is clinics and hospitals, on a regular basis. At times, their medical problems do involve emergencies which require a rapid transport to the hospital, and again are in need of means of personal transportation. Because of the HIPPA regulations, I am unable to give you specific information about their medical conditions. This information will need to come from both Mr. and Mrs. Kobs directly.

Sincerely,

/s/ Neal A. Melby, M.D.
Neal A. Melby, M.D.

NAM/mas

MARY KAY FISHER, PSY.D.
THE SANCTUARY FOR WOMEN AND GIRLS
715 ORANGE ST.
HUDSON, WI 54016
(715) 386-1634

November 27, 2002

Elvis Kevin Kobs
65 County Rd. M
Star prairie, WI 54026

Dear Mr. Kobs:

Enclosed are 3 copies of my report detailing the results of psychological testing performed on November 22, 2002.

Because I neglected to have you sign an authorization to release the information directly to your physician. I am sending all copies to you, and will leave it to you to distribute them in whatever way you deem appropriate.

Thank you for the opportunity to work with you. I wish you the best of luck in your future endeavors.

Sincerely,

/s/ Mary Kay Fisher, Psy.D.
Mary Kay Fisher, Psy.D.
WI Lic. #2325-057

ELVIS KEVIN KOBS **D.O.B. 1/25/01** [sic]
November 27, 2002 **Test Date: 11/22/02**

INTRODUCTION

Elvis K. Kobs is a 51-year old male who was referred by his physician, Dr Neal Melby, for evaluation of cognitive and memory functioning, subsequent to a work-related

accident on 1/4/02. A mental status exam, Wechsler Memory Scale (WMS-III), and Wechsler Adult Intelligence Scale (WAIS-III) were administered.

CHIEF COMPLAINT

Mr. Kobs complains of short-term memory impairment, difficulty with comprehension of new material, concentration deficits, sad/worried mood, irritability, decreased frustration tolerance, cognitive slowing, trouble with planning/sequencing/organization, poor mental control, and constant headaches. Brain imaging revealed a white mass in "left central lobe," according to the patient; however, a physician told him that that finding "wasn't related to memory centers."

HISTORY

Mr. Kobs was a financial manager for 21 years. He always had a good head for numbers, and a good memory for facts and figures. Within the past 3 years, his wife was diagnosed with cancer. She has received treatment, and the cancer is currently in remission. She also suffers from lupus, diabetes, and mytral valve prolapse.

In 1998 or '99, Mr. Kobs hit his head on a steel cabinet at work. He experienced memory impairment after this injury. Since then, he has used note and other mnemonic strategies to get by. He sustained another work-related injury on January 4, 2002, this time falling 35 feet and landing on a concrete floor. Since then, cognitive deficits have increased substantially. The following medications are prescribed:

- Effexor
- Oxycontin
- Celebrex
- Lipitor
- Prevacid

Alcohol and Substance Abuse History: Mr. Kobs underwent counseling for a drinking problem several years ago. He denies current alcohol use. He has never used illegal drugs.

MENTAL STATUS

General Appearance: Elvis Kevin Kobs presented as a personable middle-aged gentleman with a ready handshake and an engaging interpersonal manner. Height was perhaps a little taller than average; he was a little overweight. Gait and station were unremarkable.

Attitude and Behavior: Mr. Kobs was open and direct concerning his condition, and his fears about its long-term implications. He tended to be very talkative. There was a tendency to confabulate, which seemed to be a defensive response to his inability to access memories or information. He seemed very invested in doing well on the testing, despite its stated purpose being to document deficits. It appeared that he would much rather find out that he was intact and healthy. His approach to testing was conscientious, his application steady. Results are judged to be reliable estimates of current functioning.

Mood and Affect: Mood was sad and worried; affect was dysthymic, of mild intensity and constricted range. Interpersonal good cheer seemed rather forced. He acknowledged excessive worry, tension, and irritability.

Vegetative Signs: Sleep and appetite are both impaired. There is difficulty concentrating; he cannot watch a TV show through to the end, or finish a computer game. He reads very slowly, forgetting what he read, and has difficulty with comprehension. No psychomotor abnormalities were observed; however, cognitive processing appeared slowed.

Thought Process and Content: Narrative stream was halting; retrieval difficulties were apparent. Speech was logical and goal-directed. No signs of formal thought

disorder were reported or observed. Suicidal and homicidal thinking were denied.

Attention and Concentration: Mr. Kobs was capable of a steady application of effort. However, processing was so slow that he would occasionally lose track of the task. It was also clear that he had to work very hard to accomplish a mental task, and the effort involved was exhausting. It would appear, then, that attention/concentration per se is not the deficiency; rather, mental stamina, speed, and control are the areas of greatest impairment.

Abstraction, Insight, Judgment: Answers to questions designed to tap abstract thinking suggest at least average premorbid intelligence. Judgment appears good. He does not seem to be very introspective by nature; insight is judged to be fair.

Memory (WMS-III Results):

PRIMARY INDEXES	SUM OF SS	INDEX SCORE	95% CONF. INTERVAL	PR	QUALITATIVE DESCRIPTION
Auditory Immediate	16	89	83-97	23	Low Average
Visual Immediate	13	78	72-92	7	Borderline
Immediate Memory	29	80	74-90	9	Low Average
Auditory Delayed	14	83	76-94	13	Low Average
Visual Delayed	11	72	67-87	3	Borderline
Auditory Recog. Del.	7	85	78-100	16	Low Average
General Memory	32	75	69-85	5	Borderline
Working Memory	15	85	78-96	16	Low Average

(Index scores have a mean of 100 and a standard deviation of 15. Obtained scores are assumed to contain error variance. The confidence interval corrects for this by providing a range within which the "true score" is expected to fall.)

Results show an individual whose overall memory functioning falls in the borderline range, at the 5th percentile compared to the standardization sample. Working memory fares slightly better, in the low average range at the 16th percentile. Although a casual glance might suggest that visual memory is more impaired than auditory memory, these differences do not reach statistical significance. Reference to the large overlap between confidence intervals will help explain why this is so.

* * *

SUMMARY

In sum, this gentleman does appear to suffer from deficits in executive functioning, including sequencing, planning, mental organization, and mental control. Cognitive processing is markedly slowed, stamina is weak, and these, in turn, affect concentration. Deficits in working memory are moderate to severe, with deficits increasing as task complexity increases. Remote semantic retrieval is at least mildly impaired – with slowed processing speed exacerbating the retrieval difficulty. Auditory and visual memory, both immediate and delayed, are impaired as well. In short, there are global memory deficits, with the possible exception of autobiographical event memory.

Judging from clinical observation and test results, the conclusion is that this patient meets criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury. In addition, the stress of his wife's illness, financial difficulties, embarrassment and frustration related to his

condition, and uncertainty about his future capacities and options are causing a mood disturbance best conceptualized as an adjustment disorder with depression and anxiety.

DSM-IV DIAGNOSIS

Axis I:	294.1 Dementia due to head trauma 309.28 Adjustment Disorder with Depression and Anxiety
Axis II:	V71.09 None
Axis III:	854.00 Head injury
Axis IV:	Severe: Functional difficulties, wife's illness, financial difficulties
Axis V:	Current GAF: 51

I appreciate the opportunity to be of service. Please let me know if there's anything else I can do.

Respectfully submitted,

/s/ Mary Kay Fisher, Psy.D. 11/27/02

Mary Kay Fisher, Psy.D. Date

WI Lic. #2325-057

[LOGO] Midwest
Spine Institute
Member of Midwest Spine & Orthopaedics Network

Orthopaedic surgeons specializing in the treatment of spinal diseases, injuries and deformities

651.430.3800
800.353.7720
Fax 651.430.3827
www.spineline.com

Midwest Professional Building
1950 Curve Crest Blvd. W., #100
Stillwater, MN 55082

July 30, 2002

David M. Erspamer
Erspamer Law Office
Suite 165
314 Keller Avenue North
Amery, Wisconsin 54001

RE: Elvis (Kevin) K. Kobs
Date of Birth: 01-25-1951
Date of Injury: March/April, 1999; and
June/July, 1999

Dear Mr. Erspamer:

This is in response to your letter of May 24, 2002.

According to Mr. Kobs, it was some time in August 1999/September 1999, he was sitting at his desk and bent over to open a low drawer. He felt immediate low back pain. He saw Dr. Melby and had x-rays and received medication. At the end of September 1999, he ran into a steel cabinet at work and had a bruise on his head. He was seen in the emergency room for neck pain, nausea, and headaches.

I initially saw him December 29, 1999 for complaints of constant neck pain and headaches. He also had constant upper back pain and intermittent arm pain to the elbow with numbness and tingling in his hands. He had constant low back pain with right leg pain to the calf. On cervical examination, he had a positive Adson's on the right and a positive Tinel's at the right elbow along with positive Tinel's at both wrists. He had a history of polio and could not walk on his heels because of that. He had pain over the left SI joint to palpation. Strength of the anterior tib and EHL bilaterally was 4/5 from his prior polio. Cervical x-rays showed mild calcification of the ligament anteriorly at C6-7 but otherwise were normal. Lumbar x-rays were normal. Lumbar MRI from December 17, 1999 showed degenerative changes within the annulus at L3-4 with dehydration and bulging at L4-5 and L5-S1. I recommended physical therapy, Anaprox, and a cervical MRI scan.

A cervical MRI scan completed January 4, 2000 showed a small disc herniation at C5-6 and degeneration at C3-4. He was still having headaches at his February 11, 2000 office visit, but I felt that the changes on the MRI scan were not necessarily related to his complaints. I recommended that he follow-up with neurology.

I did not see Mr. Kobs again until May, 25, 2002. He reported falling thirty-five feet onto concrete. He apparently was hospitalized on January 3, 2002 at New Richmond Hospital. He fractured his hand and injured his left knee and left leg. I saw him for complaints of pain in the neck, midback, low back, and left leg. On examination that day, he had general pain to palpation throughout the spine. Flexion of the lumbar spine brought his fingertips to eight inches from the floor. Motor and sensory examinations

were normal in both upper and lower extremities. Cervical spine MRI scan from March 8, 2002 showed mild degenerative disc disease which I felt was not significantly related to his ongoing problem. Lumbar MRI scan from April 30, 2002 demonstrated degenerative disc disease at L3-4 and L4-5 with mild stenosis at both levels. There was a small central herniation at L5-S1 of questionable clinical significance. I ordered a thoracic MRI which was done May 21, 2002. That scan showed mild degenerative changes in the mid and lower thoracic spine without compression fractures or herniations.

Mr. Kobs' past medical history, to my knowledge, included an incident when he slipped at work in December 1998 and had immediate neck and low back pain. He apparently saw Dr. Melby for three or four months and had a complete recovery and had no further treatment until the incident in August/September 1999 when he bent over.

It is my opinion, after reviewing the available information, that Mr. Kobs has a permanent partial disability of 4% to the body as a whole for his cervical condition based on Wisconsin Worker's Compensation Statutes. I feel that 50% of his current cervical condition is due to the September 1999 incident when he hit his head, and 50% of his cervical condition is due to the prior fall on the ice at work in December 1998. With regards to his lumbar condition, I feel he has a 4% permanent partial disability to the body as a whole based on Wisconsin Worker's Compensation Statutes. Fifty percent of his current lumbar condition is due to the August/September 1999 bending incident and 50% is due to the prior fall on the ice in December 1998. The fall in January 2002 was a significant aggravation to a preexisting degenerative condition. I have recommended continued conservative treatment including epidural

steroid injections in the cervical and lumbar spine. He does not require surgery. He should follow-up with Dr. Melby, and I would be happy to see him as-needed.

If you have further questions, feel free to contact my office.

Sincerely,

/s/ Thomas Rieser
Thomas V. Rieser, M.D.

TVR//kms

MEI

MEDICAL EVALUATIONS INC.

January 30, 2003

Ms. Cynthia K. Thurston
McCollum, Crowley, Vehanen,
Moschet & Miller, Ltd.
1801 West Knapp Street, Suite 6
Rice Lake, WI 54868

RE: Elvis Kevin Kobs
Your File Number: 10587 54W
MEI Invoice Number: 37301

Dear Ms. Thurston:

I had the opportunity to evaluate Mr. Elvis Kevin Kobs in St. Paul, Minnesota, on January 2, 2003, for the purpose of an Independent Medical Evaluation.

HISTORY

Mr. Kobs is a 51-year-old male who is noted to be a somewhat poor and vague historian. He states that he started employment for Bernards Northtown as a Senior Finance and Lease Manager beginning either in 1992 or 1994. Prior to that, he worked for 13 years as a business manager for a company on the east coast.

* * *

He states that he has been out of work since early January 2002. He states that after he hit his head, he could not remember things. He states that only he knew about it. He states that he took a lot of notes and kept messages so he could continue to keep going without anyone else really knowing. He states that now it is at the point where it is hard to remember things and he is very upset about it. He

thought it would get better with time, but it has not. He states that he has had tests on everything and he has seen multiple specialists. He states that with the last test that he had, he was diagnosed with dementia. He has short-term memory loss. He states that all of these are detailed in a report from his primary doctor, Dr. Neal Melby of New Richmond. He states that Dr. Melby saved his wife from cancer.

CURRENT STATUS

Mr. Kobs states that he continues to have symptoms. He has pain in the low back, neck, and shoulders. He has daily headaches and nothing helps. He states that he cannot take ibuprofen because of gastrointestinal problems. He takes Tylenol Arthritis, which helps a little. He states that he has intense frontal headaches that will occasionally cause him to throw up. He states that he has a Jacuzzi at home and he sits in it a lot and this helps some. He states that he has a moist heating pad. He will use this on the base of the neck and it helps his head and neck. He states that his legs swell. He states that both knees hurt. He states that his calves are hard as rocks by the end of the day. He has shooting pain in the low back and buttock areas if he bends over. If he puts his head down in a flexed position, he gets pain from the neck down to the middle of the back. He states that he cannot drive with his hands up or his hands go to sleep. This involves the ulnar three digits of both hands, but sometimes his entire arm is dead from the elbow down. He states that he has had three cortisone injections into his back and these have not helped. He states that it is aggravating, frustrating, and "stupid."

He has symptoms on a daily basis. He notices that for the first three to four hours in the morning his symptoms are unbearable. It takes him three to four hours to get on an even keel before he can do anything. It hurts to stand in the mornings. He sits in the shower and takes a shower as hot as he can tolerate and then he sits in a Jacuzzi for one-half hour. He then loosens up. He states that he is in pain the rest of the day. He does get a little bit better, but then his legs swell. His back pain, however, does not get better, and gets worse as the day goes by. He sits in a recliner with the heat on or will put his legs up in bed with heat.

He does have sleep disturbance due to symptoms. He states that he has gone three days without sleep and this is even with the medications. Any activity will increase symptoms. When reading, his head will pound and he cannot do it. He can only spend a short time on a computer. He states that any activity that he does, he can only do for short periods. Driving is terrible. He states that he had a one hour and 20 minute drive to this appointment. He states that his left leg will bother him and kill him. He states that he gets by with short trips. He lives six miles from town.

He states that from an activity standpoint he has given up everything including bowling, hunting, fishing, and dancing. He can only fish in one spot for an hour. Nothing really helps reduce symptoms. Medications really do not help much.

From a treatment standpoint, he states that he goes in for follow-up visits with his doctors and is on medications. He had physical therapy that would take the edge off for about two to three hours, but, again, nothing really helped. He states that he is not getting any treatment now

because he has no insurance. He states that he was given home exercises that he does. It appears that exercises are rather minimal. He states that he cannot recall what these exercises are without the sheet to review.

He states that he is not getting any better. Today is a bad day in terms of symptoms.

* * *

There are marked inconsistencies in his neuropsychological testing and opinions regarding his cognitive deficits. I find evidence from a musculoskeletal standpoint to suggest symptom magnification and functional overlay, and find evidence to suggest that his subjective complaints are not in fact consistent with objective examination findings or radiologic findings. These same opinions have been alluded to by his treating physicians in the past, including orthopedic surgeons and neurologists. His tendency to somatization of his psychological stressors has been well documented over the years. There is, therefore, no evidence that Mr. Kobs would be considered disabled from gainful employment from a musculoskeletal standpoint. It does appear that he had a significant change in his overall abilities to function on several levels following his home-related fall of January 2002.

If any further information is needed, please feel free to contact me through Medical Evaluations, Inc.

Sincerely,

/s/ Nolan M. Segal, M.D.
Nolan M. Segal, M.D.
Orthopedic Surgeon

NMS/sf

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Mayo Mail Code 295
420 Delaware Street, Southeast
Minneapolis, MN 55455

Office: 612-625-9900
Fax: 612-625-7950
www.neurology.umn.edu

Department of Neurology
Medical School

SUMMARY OF NEUROPSYCHOLOGICAL EVALUATION

Patient's Name:	**KOBS**, Elvis Kevin
Medical Record #:	**0050132702**
Date of Evaluation:	August 22, 2002
Referring Physician:	Neal Melby, M.D. New Richmond Clinic New Richmond, WI

I. REASON FOR REFERRAL

Mr. Kobs, a 51-year-old, right-handed man, was evaluated for documentation of his cognitive baseline in the setting of his complaints about his memory. Mr. Kobs suffered what sounded like a mild closed head injury in 1999, followed by a fall from a roof onto his left side which spared his head this past January. Mr. Kobs, according to office notes from Dr. Melby, began complaining about memory loss after the fall from the roof.

* * *

Regarding the memory loss he reportedly experienced after he hit his head, he reported that at work his general manager kept giving him sly (Mr. Kobs used the word

"slide") comments that he, the manager, could match Mr. Kobs's brain any day. Mr. Kobs reported that he did not understand where his general manager was "coming from," since he has reportedly had twenty-six years of experience as a business manager, and "never, ever made any mistakes in [my] life as far as [my] work." Mr. Kobs reported that subsequent to the incident, he started having to take a lot of notes at work. He reportedly used to deal with twenty or more banking institutions and could remember their fax and phone numbers, but started having to look the numbers up in his computer. He reportedly recently went to town and could not remember his home phone number, so he went to his daughter's to ask her. He commented, "I want to know why this is happening." Mrs. Kobs reported that her husband's short-term memory is getting worse and worse, but his long-term memory is fine. When Mr. Kobs was asked about his ability to pay attention, he denied any problems, but Mrs. Kobs reported that he "almost just doesn't get it." Mrs. Kobs also reported that she has to write out the checks because "he forgets." Mr. Kobs, however, reported that he has cashed in his 401K and brought his first and second mortgages up to date.

* * *

Mr. Kobs might have presented himself in such a way as to confirm his own view of himself as memory-impaired and brain-injured. However, there are numerous implausible aspects of his performance which raise questions about the effort he exerted throughout this evaluation. First of all, Mr. Kobs's IQ, as measured here, was found to be 80, that is, just barely within the low average range. This is simply not believable. There is no possible way that a head injury of the severity described by Mr. Kobs could have lowered

his IQ to this level. Furthermore, there were findings within the IQ testing that were also highly unlikely. Mr. Kobs obtained a score on Vocabulary, which measures knowledge of vocabulary, that was in the low average range. This seems an unusually low score for a man who finished two years of college at Boston College and who used to make speeches and sell cars, a man who reportedly was making an average of $80,000 a year or more and who probably relied on his verbal skills to help him make that kind of money.

* * *

With respect to personality functioning, as discussed above, Mr. Kobs appears to be having a conversion reaction, e.g., he may be converting psychological problems into physical symptoms, without any awareness of his behavior. Thus, the results of the MMPI-2 suggested that these efforts to make himself look cognitively impaired were not done deliberately, e.g., with the intent to deceive. Mr. Kobs's view of himself as physically unwell and cognitively impaired could have skewed his performance unintentionally in the direction of impairment, when in fact these results, when interpreted in light of all the available information, suggest the opposite – that he is not memory disordered or cognitively impaired. In other words, Mr. Kobs seems to have convinced himself that he has memory impairment, with, it would seem, Mrs. Kobs's unwitting reinforcement. It was clear that she perceives him as having deteriorating short-term memory, but did not provide a lot of history to substantiate her view.

* * *

In summary, the results were not consistent with the presence of memory problems secondary to a closed head

injury. There was in fact no real evidence that he had sustained a closed head injury, e.g., an injury that would have produced cognitive effects. Mr. Kobs's performance was thought to be influenced by his conviction that he is ill and his denial of physical and cognitive well-being. Although an absence of progressive memory loss should be good news, it probably will not be greeted with much enthusiasm. There was evidence of a tendency to convert stress reactions to physical symptoms, and to be unaware of underlying psychological conflicts or concerns. Mr. Kobs was thought to be experiencing more psychological distress than he was willing to acknowledge. It was recommended that he receive supportive counseling. A referral to William Robiner, Ph.D., ABPP, L.P. or Diane Bearman, Ph.D., L.P., health psychologists in the Department of Medicine here at Fairview-University Medical Center, is suggested. This referral would be made by Dr. Melby. Dr. Robiner may be reached at (612) 624-1492, and Dr. Bearman at (612) 624-0933.

With regard to the issue of a return to work, Mr. Kobs passed along a variety of disability forms to be completed. It is this examiner's opinion that he is not cognitively disabled or memory impaired. However, he appears to have some psychological disturbance at this point which would render it difficult for him to be a fully engaged worker, e.g., he sees himself as too sick to work and he is sincerely convinced of this view. Further, this view has been reinforced by his family. He has physical injuries and chronic low back pain. It is therefore also recommended that he be referred to Miles Belgrade, M.D., at Fairview-Riverside, for help in dealing with what appears to be a chronic pain syndrome. Dr. Belgrade may be reached at

(612) 273-5400. Again, Dr. Melby would make this referral if he deemed it appropriate.

The opportunity to address questions regarding Mr. Kobs's cognitive status is appreciated. Thank you for the very interesting referral. If there are questions about this evaluation, please do not hesitate to call (612) 625-7423.

/s/ Mary Sullivan, Ph.D., L.P.
Mary Sullivan, Ph.D., L.P.
Assistant Professor of Neurology

[LOGO] GARY L. FISCHLER ASSOCIATES, P.A.

604 Parkside Professional Center
825 South 8th Street
Minneapolis, MN 55404

[Names And Telephone Numbers Omitted In Printing]

PSYCHOLOGICAL EVALUATION

***Client Name*:**	Elvis Kobs
***Date of Evaluation*:**	March 28, 2003
***Referred by*:**	Elite Physicians, Ltd.
***Date of Report*:**	March 30, 2003

* * *

RELEVANT HISTORY (according to the subject): Mr. Kobs reports that he quit high school when he was 16 years old in order to get married, after his girlfriend became pregnant. He later earned his high school diploma through a home schooling program sponsored by a university in Illinois; he claimed he could not recall the name of the university. Prior to quitting school, he says his grades were "immaculate" and all As and Bs. He states that he retook an algebra course because he "didn't pay attention" the first year. He says he "aced it" the second time. Mr. Kobs denies any history of being diagnosed with a learning disability or receiving special education services in school. He also denies any history of behavioral problems in school. While he says he was shy in high school, he also was President of his junior class and was elected to be the Master of Ceremonies for the prom. He says he was a bit of a "geek" in school and seemed to need to work harder to earn good grades than other students. He denies any known history of attention-deficit problems in school. After moving to Boston in 1981, and living there for a period of time, Mr. Kobs attended Boston College for night school for

a couple years, and he suspects her [sic] earned Bs in those classes. Also, while living in Massachusetts, he successfully completed a course to get his real estate license.

The client reports that he was most recently employed at a mortgage finance company, and that lasted about 90 days until the end of 2002. He says he was offered a position by acquaintances he had met while working at the auto dealership. He reports that he had trouble doing the paperwork portion of that job, such as organizing the mortgage application file in the proper sequence. He was eventually encouraged to quit, and he never actually saw a loan to completion. Prior to that, he had been working for Bernard's Northtown, which is a car dealership, and his position was that of Business Manager. He was fired from that job on 5/21/02, when he received a certified letter in the mail. He was upset about that because three weeks prior, he had had a meeting with the owner and the owner commented, "You look like shit", to which the client commented, "I feel like shit." He further states that the owner had stated, "All I want you to do is get better" and he encouraged him to take some time off.

* * *

Mr. Kobs reports that in 1998 or 1999 he fell twice at work. He says he hurt his back the first time he fell. The second time, he struck his head on a steel cabinet that was situated by a door, and he hit his head has [sic] he was poking his head out to say something to someone. He hit his head on the left side (toward his forehead) and fell to his knees. He was not knocked unconscious, but he says he had little memory of what he did the rest of that day. He reports feeling nauseated. He went to the doctor the next day. He reports that he started having headaches after that incident, and had had [sic] never suffered from headaches before. Eventually, he had a CT scan and the

radiologist told him there was "a spot in the center of by [sic] brain" but that the doctor did not have any idea what it was, and tried to reassure that [sic] client that he had nothing to worry about. His regular doctor had agreed to do some more testing, but by that time, the client no longer had insurance coverage.

Mr. Kobs states that he began noticing memory problems from the time he hit his head on the steel cabinet. At work, he says he started to rely on notes to remember things and that he had hoped nobody would find out what was going on. At this point, he says his memory problems are "very sporadic" and that he is liable to forget a number of different things. For example, he says that his daughter had been over to visit the other day with his granddaughter, and he had enjoyed the company of his granddaughter for a while. Later that day, after his daughter and granddaughter had left, he had talked to his son-in-law and had asked the client, "Was your daughter out today?" He told his son-in-law that he had not seen her that day. Then, the client's daughter called him and asked, "Didn't you remember me being there?" He states that he had remembered they were there, but thought it was the day before. Mr. Kobs also reports that he forget [sic] numbers like never before, and that he used to have 100's of phone number and Fax numbers memorized. He says he even forgets his own phone number, or at least turns the numbers around.

Mr. Kobs reports that he feil from his roof, and he estimates that it was 35 feet, and he landed on his left side and suffered several injuries. He does not recall having the falling sensation, but he remembers getting the wind knocked out of him and not being able to breathe. However, he says he was not knocked unconscious. That

occurred January 2002. He says he has had chronic pain since then, and now has "whole body pain."

* * *

DIAGNOSTIC IMPRESSIONS:

Axis I. 1. Depressive disorder, NOS (311.0), with anxious features.

2. History of alcohol abuse (305.0), in remission.

3. Probable Pain disorder associated with both psychological factors and injury (307.89)

2. [sic] R/O Malingering

Axis II. Diagnosis deferred.

Axis III. Possible concussion in 1998 or 1999, by client's report; history of coronary disease; history of back/knee injury, secondary to fall; polio as a child.

Axis IV. Severe financial distress; chronic medical problems

Axis V. Current GAF = 70

SUMMARY OF REFERRAL QUESTIONS:

1. **What is your diagnosis?** See above. Mr. Kobs shows a pattern of cognitive performance on current and past testing that shows inconsistency, and these inconsistencies were well documented in the neuropsychologcial assessment done on 8/22/02. Based on observations and test results from the current evaluation, this examiner concurs with the opinion of the examiner from the 8/22/02 evaluation, i.e., that the pattern of deficits seen in that examination is not due

to trauamtic brain injury and that significnat [sic] emotional and/or motivational issues are very likely part of the clinical picture. The purpose of this evaluation was not to do another comprehensive assessment of Mr. Kobs' neuropsychological functioning, but rather provide a context in which to explore the possibility of symptom exaggeration [sic] the part of the client.

It was notable that of the two traditional neuropsychologial tests administered for this current evaluation (RAVLT, BCT), neither produced a pattern consistent with significant cognitive impairment, much less dementia – even if the client was exaggerating. For example, the results of the memory test (RAVLT) showed low average performance on most scores. Given this finding, along with convincing evidence from the measures of symtom [sic] exaggeration, it seems safe to conclude that the client is not suffering from dementia. Unfortunately, however, it is not possible to determine the extent of any mild deficits that might be present from a possible concussive injury five years ago.

2. **What are the objective medical findings?** Please see the narrative above, including scores from testing.

3. **What is your assessment of the claimant's subjective complaints?** Mr. Kobs appears to be genuinely concerned about his cognitive functioning, and he considers himself to have dementia, likely because he was diagnosed with that in October 2002. However, his pattern of deficits is not consistent with degenerative dementia, or dementia due to brain injury. Unfortunately, there is strong evidence that he consciously or unconsciously exaggerated symptoms for this evaluation. While one cannot automatically conclude that he showed the same pattern with the previous two neuropsychological evaluations, there is

sufficient evidence to at least question the findings. Also, it is notable that for the current evaluation, the client was obviously aware that his motivation might be suspect because one of the first things he said was to reassure the examiner that he was not going to "lie."

4. **What specific impairments (functional limitations) are present?** From the current evaluation, there are few, if any, functional limitations that can be discernable from the data because the validity of the data is suspect as it pertains to his actual cognitive abilities. There is a moderate chance that his emotional difficulties, namely depression, are contributing to his subjective cognitive problems.

5. **Is the claimant is** [sic] **unable to return to work without restrictions? If there are restrictions, please specify.** There is no clear answer to this question with the known data.

6. **If the claimant is unable to return to any job, what is the expected length of disability?** Based on the cognitive data and their assumed questionable validity, one cannot make firm predictions about his ability to return to work. It seems unlikely that his [sic] totally unfit to work, based on his subjective cognitive deficits.

7. **Is there any period of time after 7/4/02, based upon your review of the medical records, when the claimant would have been considered totally disabled?** With all likelihood, the answer is probably "No", based solely on the cognitive data.

8. **Complete the appropriate testing to elicit your opinion of the claimant's condition?** See above.

9. **Complete the *Mental Residual Functional Capacity Assessment Form.*** See attached.

All recommendations are advisory only and based upon the best professional judgment of the examiner, considering all the data available at this time. All recommendations are based on a reasonable degree of psychological certainty, as absolute predictions are not possible.

/s/ P Sarff, Ph.D.
Philip Sarff, Ph.D.
Licensed Psychologist

[LOGO]

Elite Physicians®, Ltd.

A Subsidiary of **NMR**

Providers of
Evidence-Based Medical Reports

October 15, 2002

Ms. Connie DuBose
United Wisconsin Group
P.O. Box 2013
Milwaukee, WI 53201

RE: Elvis Kobs
CLAIM #: 02103513
SS #: 387-50-4896
NMR #: D20628.01

Dear Ms. DuBose,

Thank you for referring this file for review, to determine Mr. Kobs's level of functionality. Specific issues will be addressed at the end of the report.

ORTHOPEDIC ASSESSMENT: A thorough review of the medical records was completed. According to the medical records, from an orthopedic surgeons perspective, the primary diagnosis affecting Mr. Kobs' ability to work is status post arthroscopic surgery to the left knee secondary to a fall. Other associated diagnoses are hypercholesterolemia, coronary artery disease, asthma, tobacco abuse, status-post coronary angioplasty on three separate occasions, and coronary artery disease. A final associated diagnosis is depression and anxiety.

Mr. Kobs is now status post fall from a roof at his home on or about 01/04/02. He fell approximately 30 to 35 feet. During that fall, he sustained multiple contusions, a

sprain of the left shoulder, trauma and contusion to the left ankle with contusion to the left knee. He was found to have a joint effusion of the left knee, which was now status post arthroscopic surgery; however, the arthroscopic surgical operative report was not submitted for review.

* * *

The history and physical and testing do support the diagnosis of his treating physicians; however, they are not functionally embarrassing enough from an orthopedic standpoint that would preclude him from being gainfully employed in a sedentary capacity either as an accounts manager, business manager, or finance director in car sales. Mr. Kob has problems from his alleged short-term memory and depression, which is more psychological and psychiatric in nature than orthopedic.

* * *

If you have any additional questions, please contact our office.

Sincerely,

/s/ Richard A. Silver, M.D.
Richard A. Silver, M.D.
Board of Certified Orthopedic Surgery
Fellow International College of Surgeons
Fellow American Academy of Disability
Evaluating Physicians
Fellow American College of Forensic Examiners
American Board of Forensic Medicine
IL. License # 036-040535
AZ. License # 5135

PSYCHIATRIC ASSESSMENT: A thorough review of the medical records was completed. From a psychiatric

perspective according to the medical records, the primary diagnosis affecting Mr. Kobs' ability to work is that of depression.

* * *

The history and testing support the diagnosis of his treating physician; however, according to objective evidence in the medical records, Mr. Kobs does not have a significant impairment that would prevent him from performing essential functions of his employment. There are no specific limitations regarding ability to function related to Mr. Kobs' impairments. No specific restrictions due to safety issues should be placed on Mr. Kobs. The medical records show that Mr. Kobs is receiving appropriate and regular medical care. I would not suggest any other treatments other than supportive psychotherapy.

* * *

If you have any questions or concerns regarding this evaluation, please contact our office.

Sincerely,

/s/ Reginald A. Givens, M.D.
Reginald A. Givens, M.D., Psychiatrist
Diplomate American Board of Psychiatry
and Neurology, Adult Fellowship
Training in Psychosomatic Medicine
Diplomate American Board of
Medical Consultants
IL. License # 003-036-093992-01
MO. License # MDR8N85

08/17/03 **Francine Blaha RN.** – Records received and reviewed.

* * *

SUMMARY:

Without having to go into great detail. Based on the objective medical documentation provided for review, the objective data does not even come close to the massive subjective complaints of the claimant. Uphold denial.

UWG United Wisconsin Group

P.O. Box 2013
Milwaukee, WI 53201
262-787-7400/1-800-452-4250
FAX 262-787-7575

September 4, 2003

Gerald Gust
Novitzke, Gust, Sempf & Whitley
314 Keller Avenue N
Amery WI 54001

RE: Long Term Disability – Elvis Kevin Kobs
SS#: 387-50-4896
Group #: 702273/0000

Dear Mr. Gust:

This letter is in response to your claim appeal of the denial of Long Term Disability benefits. Our Appeal Committee has reviewed the file.

The group policy states:

DEFINITION OF LONG TERM DISABILITY

"TOTAL DISABILITY" and **"TOTALLY DISABLED"** means that due to Injury and/or Illness,:

1. the Insured cannot perform the material duties of his or her regular occupation during the Elimination Period and the following 24 months of the Benefit Period; and

2. after 24 months of the Benefit Period, the Insured cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training or experience.

"PARTIAL DISABILITY" and "PARTIALLY DISABLED" means that due to Injury and/or Illness, the

Insured is unable to earn 80% of his or her monthly Indexed Pre-Disability Earnings because of that Injury or Illness and is either:

1. during the first 24 months of the Benefit Period, unable to perform all material duties of his or her regular occupation on a Full-Time basis, but is performing at least one of the material duties of his or her regular occupation or another occupation on a part-time or Full-Time basis; or

2. after the first 24 months of the Benefit Period, unable to perform the material duties of any occupation for which he or she is or may be reasonably fitted by education, training or experience.

When Totally or Partially Disabled based on objective medical findings, the Insured must be under the Regular Care and Treatment of a Physician and provide documentation of same as required by Us. The Insured may be required to see a Physician selected by Us for an independent medical examination.

A thorough review of Mr. Kobs' medical history was completed. We gathered medical information from all sources known to us, including Worker's Compensation. Our findings are that there was no significant change in Mr. Kobs' neurological symptoms, subsequent to his January 3, 2002 claims for disability. We lack objective medical evidence to support the numerous subjective complaints and find no basis for a physically disabling condition.

The Appeal Committee finds that our original decision to deny benefits was correct, under the terms of your Long Term Disability policy. No benefits are payable on Mr. Kobs' claim.

We reserve all rights and defenses, either expressly stated or implied.

This is the full and final decision of the Appeal Committee. As such, you have a right to file a civil action pursuant to section 502(a) of the Employee Retirement Income Security Act of 1974 requesting a review of our final determination.

If you have any questions, you may contact this office at 1-800-452-4250.

Sincerely,

/s/ Julie Szemborski
Julie Szemborski, FLMI, ALHC, HIA, ACS
Manager, Life & Disability Claims
United Wisconsin Group

cc: Bernard's Northtown, Inc.

STATE OF WISCONSIN POLK COUNTY
CIRCUIT COURT

Washington Mutual Bank, FA,
c/o Chase Manhattan Mortgage
Corporation (CA)
10790 Rancho Bernardo Drive
San Diego, CA 92127

Plaintiff,

v.

Elvis K. Kobs f/k/a Eugene K. Kobs
and Donna P. Kobs
65 County Road M
Star Prairie, WI 54026

Defendants.

COMPLAINT
Case No. 03 CV 165

Case Code 30404
(Foreclosure of Mortgage)
The amount claimed exceeds $5000.00

Plaintiff, by its attorneys, GRAY & END, L.L.P., pleads as follows:

1. The plaintiff is the current owner and holder of a certain note and recorded mortgage on real estate located in this county, true copies of which are attached hereto as Exhibits A and B and incorporated by reference.

2. The mortgaged real estate is owned of record by Elvis K. Kobs and Donna P. Kobs.

3. The defendants have failed to make contractual payments as required, and there is now due and owing to plaintiff the principal sum of $297,848.78 together with interest from December 1, 2002.

4. The plaintiff has declared the indebtedness immediately due and payable by reason of the default in the payments and has directed that foreclosure proceedings be instituted.

5. The mortgaged premises is a parcel of land which is less than 20 acres; with a one to four family residence thereon which is occupied as the homestead of the defendants; said premises cannot be sold in parcels without injury to the interests of the parties.

* * *

WHEREFORE, the plaintiff demands:

1. Judgment of foreclosure and sale of the mortgaged premises in accordance with the provisions of Section 846.101 of the Wisconsin Statutes.

2. That the amounts due the plaintiff from the mortgagor defendants for principal, interest, taxes, insurance, costs of suit and attorney fees be determined.

* * *

GRAY & END, L.L.P.
Attorneys for Plaintiff

By: /s/ [Illegible]
Michael M. Riley
State Bar No. 1033997
600 North Broadway
Suite 300
Milwaukee, Wisconsin 53202
(414) 224-1987

STATE OF WISCONSIN ST. CROIX COUNTY
CIRCUIT COURT

Daimler Chrysler Services of North America L.L.C. f/k/a Chrysler Financial Company L.L.C.
400 Horsham Drive
Horsham, PA 19044

Plaintiff,

vs.

Donna P. Kobs
and Elvis K. Kobs
65 County Road M
Star Prairie, WI 54026

Defendants.

COMPLAINT

(Filed Mar 31, 2003)

Case No.

Small Claims – Replevin: 31003

NOW COMES the plaintiff, by its attorneys, and alleges:

1. Plaintiff seeks to enforce a cause of action arising from a consumer credit transaction which is identified in the annexed exhibits.

2. A description of the collateral which the plaintiff seeks to recover is set forth in the annexed exhibits.

3. Defendants defaulted by having outstanding an amount exceeding one full payment which has remained unpaid for more than ten (10) days after the scheduled or deferred due dates.

4. Plaintiff is entitled to a judgment for possession of the collateral but is not seeking to recover, in this action, the balance of the credit transaction which computed as of February 5, 2003 is as follows:

a.	Amount Financed	$ 19,919.90		
b.	Total of Payments (Precomputed Credit Transaction)	$		
c.	Delinquency Charges	$ 60.00		
d.	Interest	$ 5,414.20		
e.	Other _____	$		
	DEBIT SUBTOTAL			$25,384.10
f.	Less Payments	$ 5,188.12		
g.	Less Rebate of Unearned Finance Charges in Precomputed Transaction	$		
h.	Less Amount Received From Sale of Any Collateral	$		
i.	Other _____	$		
	CREDIT SUBTOTAL			$ 5,188.12
j.	BALANCE DUE ON DEFENDANTS' ACCOUNT			$20,195.98

* * *

8. Defendants have the right to cure a default under s.425.105 pursuant to a notice given under s.425.104 upon tendering to plaintiff the total payment of $1,118.20 on or before February 24, 2003.

WHEREFORE, Plaintiff demands judgment against the defendants as follows:

(A) For possession of the collateral or goods securing the consumer credit transaction;

(B) And for the costs and disbursements of this action.

BASS & MOGLOWSKY, S.C.
Attorneys for Plaintiff

BY /s/ Joshua J. Brady
Joshua J. Brady
WI State Bar No. 1041428

Subscribed and sworn
before me on March 21, 2003

/s/ Mary Martone
Notary Public, State of WI
My commission expires:
06-19-05

P.O. Address:
7020 N. Port Washington
Road
Suite 206
Milwaukee, WI 53217
Telephone: 414-228-6700

STATE OF WISCONSIN ST. CROIX COUNTY
CIRCUIT COURT

Daimler Chrysler Services of
North America L.L.C. f/k/a Chrysler
Financial Company L.L.C.

Plaintiff,

vs.

Donna P. Kobs
and Elvis K. Kobs
65 County Road M
Star Prairie, WI 54026

Defendants.

REPLEVIN
JUDGMENT

(Filed May 2, 2003)

Case No. 03-SC-480

This action having come on for hearing before the Court on MAY 5, 2003, and the defendant having failed to Answer or otherwise appear, or having appeared, failed to state a defense to plaintiff's Complaint;

NOW, upon all of the files and proceedings had herein, and upon motion of Bass & Moglowsky, S.C., plaintiff's attorneys'

IT IS ADJUDGED THAT:

1. The plaintiff is entitled to possession of the following personal property:

1999 Chrysler LHS, ID#2C3HC56G6XH642969

2. The plaintiff is further entitled to:

a) have execution issued to require the Sheriff of the County where said property may be to take the same from the defendant and deliver it to the plaintiff; or

b) to immediately exercise its right to nonjudicial recovery of said property, subject to s.425.206 of the Wisconsin Statutes; and

c) to have and recover from the defendant Court costs and disbursements in the sum of $161.00.

JUDGMENT ENTERED THIS 13th DAY OF June, 2003, FOR POSSESSION OF COLLATERAL, AND FOR THE SUM OF $161.00.

BY THE COURT:

/s/ [Illegible]
Circuit Judge/Court Commissioner
Deputy Clerk

STATE OF WISCONSIN POLK COUNTY
CIRCUIT COURT

WM Specialty Mortgage, LLC,

Plaintiff,

v.

Elvis K. Kobs f/k/a
Eugene K. Kobs
Donna P. Kobs and
Bremer Bank,
National Association

Defendants.

ORDER CONFIRMING SALE

Case No. 03-CV-165

The Honorable Robert H. Rasmussen

Upon the application of the plaintiff through attorneys, Gray & End, L.L.P., and upon the records, files and proceedings herein,

IT IS HEREBY ORDERED that the expenses set forth in the affidavit of plaintiff's counsel are hereby added to the judgment making a total sum due to the plaintiff of $367,918.16.

IT IS FURTHER ORDERED that the sale of the mortgaged premises to the plaintiff for $367,918.16 is confirmed.

* * *

IT IS FURTHER ORDERED that the plaintiff is entitled to a writ of assistance for the removal of the defendants and/or tenants/occupants.

IT IS FURTHER ORDERED that no deficiency judgment may be awarded to the plaintiff.

Dated this 24th day of May, 2004.

BY THE COURT:

/s/ Robert H. Rasmussen
Robert H. Rasmussen
Circuit Court Judge

Attorneys for Plaintiff:
GRAY & END, L.L.P.
600 N. Broadway
Suite 300
Milwaukee, Wisconsin 53202
(414) 278-8060

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

ELVIS KOBS, **Civil #: 04-C-0005-S**

Plaintiff,

v.

UNITED WISCONSIN INSURANCE COMPANY

Defendant.

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS SECOND MOTION TO CONTINUE DEFENDANT'S SUMMARY JUDGMENT MOTION FOR ENLARGEMENT OF TIME TO REPLY TO DEFENDANT'S SUMMARY JUDGMENT MOTION and TO COMPEL DEPOSITION DISCOVERY and in OPPOSITION TO DEFENDANTS MOTION FOR PROTECTION

The Defendant, Elvis Kobs, through his attorneys, Novitzke, Gust, Sempf & Whitley, by Jason W. Whitley, have moved the court for the following relief:

1. Continuance of the Defendant's Summary Judgment Motion Hearing and Enlargement of time in which to respond to Defendant's Motion for Summary Judgment and for an order to compel the Defendant to produce witnesses for depositions.

* * *

The Plaintiff needs to learn what information was available to the Defendant at the time Plaintiff made his request for insurance disability benefits and also the manner in which the Defendant handled and processed

that claim subject to the terms and provisions of its own policy. In addition, the Plaintiff needs to know whether the Defendant, in denying the Plaintiff's claims for insurance benefits, acted in a dual capacity as both insurer of the Plaintiff and the Administrator of the plan or the policy covering such a plan. This information is necessary to determine the proper standard of review because the defendant is claiming that its coverage decisions are subject to the strict arbitrary and capricious standard which properly only applies to plan administrators. Here, the defendant does not appear to be an not an [sic] administrator but rather a mere insurance company.

Pursuant to *Firestone Tire and Rubber Co. v Bruke* [sic], 489 U.S. 101, 115 (1989), if an insurance company acts in a dual capacity which places that insurer in a perpetual conflict as to both the insurer and interpreter of the plan, then the proper standard of review is de novo. *Id.*

* * *

This is an important matter because the Defendant's Summary Judgment Motion requests a determination that the standard of review is arbitrary and capricious. It is impossible for Plaintiff to respond to the Defendant's Motion in that regard unless the Plaintiff can determine the various procedures followed by United Wisconsin Company in reviewing and refusing Mr. Kobs's insurance claim.

The proper standard of review is of great importance in ascertaining whether an insurer wrongfully denied benefits under a benefits policy. Plaintiff must be able to conduct necessary discovery before he can effectively proceed on those issues.

Therefore, because the Plaintiff cannot properly defend against Defendant's Motion for Summary Judgment without obtaining certain necessary discovery material.

Dated this 5th day of May, 2004.

/s/ Jason W. Whitley
Jason W. Whitley, #1027052
NOVITZKE, GUST, SEMPF & WHITLEY
Attorneys for Plaintiff
314 Keller Avenue North, Suite 399
Amery, Wisconsin 54001
715-268-6130

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

Elvis Kobs
65 County Road M
Star Prairie, WI 54026

Plaintiff,

v.

United Wisconsin Insurance Company
P.O. Box 2013
Milwaukee, WI 53201-2013

Defendant.

Case No: 04-C-0005-S
Assigned Judge:
John C. Shabaz

BRIEF IN SUPPORT OF DEFENDANT'S MOTION FOR PROTECTIVE ORDER

* * *

FACTS

The background facts in this case have been previously set forth in the parties' briefs on file with the Court. Further, it has been established in the Court's Memorandum and Order of February 2, 2004, that the group disability insurance policy at issue in this matter qualifies as an "employee welfare benefit plan" as that term is defined in ERISA.

During the parties' 26(f) conference on January 20, 2004, the Plaintiff's counsel, Mr. Whitley, indicated that he would request the deposition of a UWIC employee subsequent to his receiving UWIC's administrative file. Dorner Aff. ¶ 4. At that time, UWIC's counsel advised Mr. Whitley that UWIC would object to depositions because

discovery in this case is limited to the administrative file under ERISA's arbitrary and capricious standard. Dorner Aff. ¶ 4. This was documented in the parties' Joint 26(f) Report dated January 27, 2004, and on file with the Court. Dorner Aff. ¶ 4.

* * *

B. Under The Arbitrary And Capricious Standard Of Review, Discovery Is Limited To The Administrative Record.

Under the highly deferential arbitrary and capricious standard of review, consideration of evidence by the court is limited only to that which was submitted to the plan's administrator at the time the claims decision was rendered. *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999) (finding that the district court erred in allowing discovery beyond the administrative record); *Winters v. UNUM Life Ins. Co. of Am.*, 232 F.Supp.2d 918, 927 (W.D. Wis. 2002). "Deferential review of an administrative decision means review on the administrative record." *Perlman*, 195 F.3d at 981-982. Inquiry into the thought processes of the administrator's staff, the training of those who considered the plaintiff's claims "and in general who said what to whom within [the administrator]" goes beyond that which is allowed under a deferential review. *Id.* The Seventh Circuit has not allowed parties to take discovery into the mental processes of the administrator's personnel in cases where an arbitrary and capricious standard governed. *Id.* at 982.

* * *

Dated this 23rd day of April, 2004.

UNITED WISCONSIN
INSURANCE COMPANY

By: Carol L. Dorner
Carol L. Dorner
State Bar. No.: 1032239

P.O. ADDRESS
401 West Michigan Street, C-10
Milwaukee, WI 53203
Phone:(414) 226-6930
Facsimile: (414) 226-6229

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI

PAMELA E. ARMSTRONG, No. 96-0134-CV-W-2

Plaintiff,

vs.

AETNA LIFE INSURANCE
COMPANY and AETNA
HEALTH PLAN and
PLAN ADMINISTRATOR,

Defendants.

DEPOSITION OF SANDRA F. FREIBURGER, a witness, taken on behalf of the Plaintiff, pursuant to Notice, on the 6th day of December, 1996, at the offices of AETNA INSURANCE COMPANY, 151 Farmington Avenue, in Hartford, Connecticut, before

JEAN M. JUSTMAN,

of AAA Reporting Company, Kansas City, Missouri.

APPEARANCES

For the Plaintiff:
MR. M. KEVIN UNDERHILL
SHOOK, HARDY & BACON, L.L.C.
1200 Main Street
Kansas City, Missouri 64105

For the Defendants:
MR. JOHN W. COWDEN
BAKER, STERCHI, COWDEN & RICE, L.L.C.
911 Main Street, Suite 2100
Kansas City, Missouri 64105

MS. SONYA D. DOCKETT
AETNA INSURANCE COMPANY
151 Farmington Avenue
Hartford, Connecticut 06156

* * *

[61] Q. (By Mr. Underhill) We spoke earlier about the savings concept. Do you recall that?

A. Yes, I do.

Q. I don't suppose that based on a particular total of savings anybody would get a bonus. Is that possible?

MR. COWDEN: Objection. It calls for speculation.

Q. (By Mr. Underhill) You can answer it if you know.

MR. COWDEN: If you know.

A. There is that possibility.

* * *

[67] Q. Have you ever gotten a bonus that took savings into account?

A. Yes, I have.

Q. And what were you told about that?

A. It was based on savings that was identified as not eligible claims for certain plans.

Q. How was the amount of your bonus calculated?

A. I'm not sure. The performance bonus program [68] stipulates a certain – certain percentage of salary. But

that is strictly left up to the manager or supervisor's discretion, supervisor discretion.

Q. So is it accurate to say that savings is one criteria in the performance bonus program?

MR. COWDEN: Do you mean for her? Are you asking about other people?

Q. (By Mr. Underhill) Yes, for you specifically.

A. For me specifically; it was one.

Q. Would you say that it is generally one?

MR. COWDEN: I object to the form. I think it calls for speculation.

A. For some people, no.

Q. (By Mr. Underhill) Are you saying that there are some employees for whom savings is not a criteria of their performance?

A. Correct. Correct.

Q. Which employees are those?

A. The ones that I'm aware of, administrative assistants, processors, customer service, member service, nurses. And that's generally speaking.

* * *

[71] Q. Can you explain what you mean by that a little bit more?

A. Your merit increase is based on your performance objectives, meeting your performance objectives.

Q. One of those objectives in your case being savings, correct?

A. Yes.

Q. When did you receive this bonus?

MR. COWDEN: Well, I object to the form of the question, using the term bonus, because the witness just used a different term. So I think it misstates her testimony. She said it was a merit increase.

Q. (By Mr. Underhill) When did this merit increase –

A. I received merit increases both in '94 –'95 for '94 and '96 for '95, as an annual merit review, a merit increase.

[72] Q. But haven't you testified that one of the criteria that went into those increases was savings?

A. One, yes.

Q. And you said you got such an increase in 1996 for 1995; is that right?

A. Correct.

Q. How many performance objectives did you have?

A. Five.

Q. And what were they?

A. I don't know if I can name all five. I can only do it because I know it visually. Medical underwriting production requirements met. Claim savings. Office service results. Project success. An example would be transition of business into other offices and the success of that. I'm

sorry. I can't flip over to the next page. I don't – I don't know.

Q. What are production requirements?

A. Turnaround time, volume per person. Utilization of resources; making sure that people are doing what they can in the allotted amount of time.

Q. When they evaluate this criteria of claims savings, how is it presented to you in your evaluation?

[73] A. As a per member per month.

Q. What does that mean?

A. The number of members divided by the claim volume gives you a PMPM, or per member per month.

Q. So do you mean a number of members covered by a particular group plan?

A. No, the entire market that I was responsible for.

Q. What would a member of that market be?

A. In the small business market, any employers insured by Aetna with employees of 300 and less.

Q. So Cohen Esrey would have been a member?

A. Yes.

Q. What period of time would you receive bonuses for? What I mean to say is, did you get these reviews quarterly or yearly?

A. Annual. And I was fortunate enough to receive one every year.

Q. Why is it calculated per month, if you were given the bonuses annually; do you know?

A. That's just an internal reporting actuarial. Actuary needs a member per month so they can determine trends and then set premiums appropriately; and if they need to do any [74] refiling of a certain premium increase, that can be taken care of.

Q. So is it fair to say that bonuses were awarded based in part on claims savings during 1995?

MR. COWDEN: I object –

A. Yes.

* * *

[76] Q. Which of your employees had claims savings as one of their performance objectives?

A. Fred Baruffi had a PMPM. And Deb DeForrest had a claim savings.

Q. So Fred Baruffi was one of your employees.

A. Uh-huh.

Q. Did you give him a merit increase in 1996 for 1995?

A. Yes, I did.

Q. How is claims savings calculated?

A. The PMPM.

Q. What does that mean?

A. The claims –

Q. I'm sorry, what is PMPM?

A. PMPM is the per member per month, which is the total claim volume divided by the claim dollars paid out equals per member per month in dollars.

Q. And that appears as a numerical ratio on –

A. Yes, it does.

Q. – an employee's evaluation?

A. Yes.

* * *

EXHIBIT 8

PRIVILEGED

Provident Internal Memorandum

To: *IDC Management Group*
Glenn Felton
From: *Jeff McCall*
Date: *October 2, 1995*
Re: *ERISA*

[Jeff, Looks good. See comment on last page.
/s/ Ken D.
10/4/95]

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. Accordingly, I have attached a rough draft of questions that should be asked in our claim investigation process. I recommend that it be used for *all* claims. The key for determining the applicability of ERISA is whether or not the employer "sponsors" or "endorses" the plan. If the employer *pays* the premium, the policy would usually, but not always, be considered to

be governed by ERISA. Salary allotment or payroll deduction arrangements, by themselves, do not necessarily mean that a policy is subject to ERISA. While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.

Another requirement needed in order to take advantage of the protection offered by ERISA, is to establish a formal appeal process for ERISA situations. When we deny a claim, we must include language in our letter that informs the claimant of the right to appeal our decision within 60 days. I have attached a copy of sample language. The appeal must be in writing and should be reviewed by a panel specifically established to review ERISA appeals. I recommend that the panel be composed of Chris Kinback, Bob Parks, Becky Absher, Tom Timpanaro and me.

We will be modifying the salary allotment agreements used at the point of sale to include endorsement language.

I am interested in any comments or feedback you may have on this issue.

JM:ajr

* * *

EXHIBIT 9

INDIVIDUAL	Ralph W. Mohney, Jr., Vice President	1194
DISABILITY	Jeff McCall, AVP	1947
CLAIMS	Ed Nanney, Legal Counsel	8243
	Tammy Weaver, Paralegal	7878
	Andrea Ridge, Exec. Secretary	1803
	Doug Freytag, VP Field Claims	1465
	Lisa Sager, Secretary	8328

* — * *

No. 05-394

In The
Supreme Court of the United States

ELVIS KOBS,

Petitioner,

v.

UNITED WISCONSIN INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

MARY C. NASH
UNITED WISCONSIN INSURANCE COMPANY
401 W. Michigan Street
Milwaukee, WI 53203
(414) 226-6510

MARK E. SCHMIDTKE*
SCHMIDTKE HOEPPNER CONSULTANTS LLP
103 East Lincolnway
P.O. Box 2357
Valparaiso, IN 46384
(219) 464-4961

*Counsel of Record

Counsel for Respondent

COCKLE LAW BRIEF PRINTING CO (800) 225-6964
OR CALL COLLECT (402) 342-2831

PARTIES TO THE PROCEEDING AND STATEMENT PURSUANT TO RULE 29.6

The petitioner is Elvis Kobs. The respondent is United Wisconsin Insurance Company ("UWIC"). UWIC is a Wisconsin stock insurance corporation organized pursuant to Ch. 611, Wisconsin Statutes. UWIC is a subsidiary of Compcare Health Services Insurance Corporation ("CHSIC"), a Wisconsin stock insurance corporation organized pursuant to Ch. 611, Wisconsin Statutes. CHSIC is a subsidiary of Blue Cross Blue Shield of Wisconsin ("BCBSWi"), a Wisconsin stock insurance corporation organized pursuant to Ch. 611, Wisconsin Statutes. BCBSWi's parent company is Crossroads Acquisition Corp. ("Crossroads"), a Delaware corporation. Crossroads is a subsidiary of Anthem Holding Corp. ("Anthem"), an Indiana corporation. Anthem's corporate parent is WellPoint, Inc., a publicly traded corporation organized and existing under the laws of the state of Delaware.

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES – Continued

STATUTES

RESPONDENT'S BRIEF IN OPPOSITION

This case is not an appropriate vehicle for resolving either of the issues raised in the Petition. It is not appropriate for resolving whether and under what circumstances an insurer generally has a conflict of interest when deciding ERISA benefit claims, because the facts of this case show that Respondent acted without bias in denying Petitioner's claim. Petitioner's argument that all insurers always act under an "inherent" conflict ignores the fact that, in deciding the claim in this case, Respondent engaged in an extensive claim review process, employed independent experts, relied on opinions generated by at least one doctor who was retained at the suggestion of Petitioner's own physician, and otherwise acted impartially. Both the district court and the Seventh Circuit emphasized these facts in upholding the denial, directly rebutting Petitioner's argument that these courts ignored any potential for bias. Thus, regardless of whether or not an "inherent" conflict exists with respect to insurers generally, any conflict was more than neutralized in this case.

Another reason that this case is not an appropriate vehicle for resolving the issue of when a conflict of interest arises is because, by failing to appeal the district court's discovery order, Petitioner waived any opportunity to develop evidence of either (1) actual bias beyond any alleged "inherent" conflict or (2) that such a conflict had an impact on the denial of Petitioner's claim. Petitioner argued to the district court that it was "impossible" to respond to Respondent's motion for summary judgment without a deposition of one of Respondent's employees. However, after the district court entered a protective order and Petitioner responded to the summary judgment

motion and lost, Petitioner never appealed the district court's discovery ruling. At this point, any opportunity to conduct discovery on the issue of bias has been waived. Although one cannot predict how this Court might resolve this issue, if this Court were to rule that something more than an "inherent" conflict is necessary to impact the abuse of discretion standard, such a decision will have no effect on this case because Petitioner has waived any opportunity to meet such a standard.

This is also not an appropriate case for resolving the second issue presented in the Petition, i.e., what impact a conflict of interest should have on the abuse of discretion standard. The strong evidence supporting Respondent's denial makes it highly unlikely that the courts below would have overturned the denial, even if less deference were applied by those courts. The district court ruled that there was "near unanimous" evidence that Petitioner's orthopedic claim was not disabling and that there was "overwhelming" evidence that Petitioner's cognitive complaints were exaggerated and that he was not cognitively disabled. The Seventh Circuit agreed, observing with respect to the cognitive claim, that at least three experts determined that Petitioner was "sandbagging" during testing, including a neuropsychologist who tested Petitioner on a referral from Petitioner's own doctor. Overall, the Seventh Circuit held that the "bulk of the evidence" supported Respondent's decision, noting that while Petitioner's claim was supported by his primary care doctor and a psychologist, "[o]n the other side of the scale were the opinions of two orthopedic surgeons, two psychologists, a psychiatrist/neurologist, and a registered nurse." In light of the lower courts' decisions that the record evidence weighed heavily in favor of Respondent's

denial, any adjustment of the amount of deference accorded under the abuse of discretion standard based on an "inherent" conflict of interest, will not likely change the final result in this case. In short, as applied to the facts in this case, the issues raised in the Petition are merely academic and the Petition should be denied.

JURISDICTION

This Court has discretionary jurisdiction to review decisions by the federal courts of appeals. 28 U.S.C. § 1254(1). For the reasons set forth herein, Respondent submits that this Court should not exercise this jurisdiction.

STATUTES INVOLVED

This case involves the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, *et seq.* ("ERISA").

COUNTERSTATEMENT OF THE CASE

Factual Background. Petitioner worked as a Business Manager for a car dealership. His occupation was sedentary, requiring Petitioner to sit eighty percent of the day, stand twenty percent of the day, and lift no more than five pounds. As a benefit of his employment, Petitioner participated in a long-term disability plan, the benefits of which were administered and insured by Respondent. Total disability benefits under the plan were payable for

up to 24 months where the employee "cannot perform the material duties of his or her regular occupation" and thereafter if the employee "cannot perform any of the material duties of any gainful occupation for which he/she is or may be reasonably fitted by education, training or experience." (P App 34a)[1]

On January 4, 2002, Petitioner was injured in a fall. Six months later, in June 2002, he underwent an angioplasty after episodes of chest pains. Petitioner received short-term disability benefits from January 4 through July 4, 2002. He then sought long-term disability benefits, alleging that he was disabled due to memory loss from prior incidents in 1998 and 1999, and that this condition was exacerbated by the fall in 2002.

After reviewing pertinent medical records, Respondent denied the long-term disability claim. The decision was based in large part on a review of Petitioner's medical information by independent physicians, board certified in orthopedic surgery and psychiatry/neurology. Following receipt of Respondent's denial letter, Petitioner filed an administrative appeal.

During the appeal stage, Petitioner submitted additional medical records and information. Respondent then requested another review of Petitioner's file by an independent physician and gathered various documents, including records from the State of Wisconsin, Department of Workforce Development, related to a worker's compensation claim that arose from the alleged incidents in 1998 and 1999. Respondent also requested an independent

---

[1] Citations to Petitioner's appendix are noted as "P App ___." Citations to Respondent's Appendix are noted as "R App ___."

psychological evaluation of the Petitioner and had a registered nurse complete an exhaustive review of the medical records and related documents in Petitioner's claim file, which at that point included notes for the time period of 1966 to 2003. At the time of Respondent's final decision, among other things, the claim file contained the following medical evidence and opinions regarding Petitioner's orthopedic complaints:

> *Neal A. Melby, M.D.:* Dr. Melby is Petitioner's primary care physician. Dr. Melby opined on several occasions that Petitioner was disabled both due to back and leg injuries and due to memory loss. (P App 54a-61a)
>
> *Thomas V. Reiser, M.D.:* Dr. Reiser saw Petitioner following an incident in 1999 and then again in May 2002, in connection with Petitioner's worker's compensation claim. After "reviewing the available information," Dr. Reiser opined that Petitioner "has a permanent partial disability of 4% to the body as a whole for his cervical condition based on Wisconsin Worker's Compensation Statutes." (P App 70a)
>
> *Nolan M. Segal, M.D.:* Dr. Segal is an orthopedic surgeon who performed an independent medical examination of Petitioner on January 2, 2003 in connection with Petitioner's worker's compensation claim. Among other things, Dr. Segal concluded that "I find evidence from a musculoskeletal standpoint to suggest symptom magnification and functional overlay, and find evidence to suggest that his subjective complaints are not in fact consistent with objective examination findings or radiologic findings." He opined that "[t]here is . . . no evidence that [Petitioner] would be considered disabled from gainful employment from a musculoskeletal standpoint." (P App 75a)

> *Richard A. Silver, M.D.:* Dr. Silver is an orthopedic surgeon who reviewed Petitioner's medical records at the request of Respondent. He concluded that the "history and physical and testing do support the diagnosis of his treating physicians; however, they are not functionally embarrassing enough from an orthopedic standpoint that would preclude him from being gainfully employed, in a sedentary capacity either as an accounts manager, business manager, or finance director in car sales." Dr. Silver also opined that Petitioner was "fit for duty at a sedentary light capacity . . . from an orthopedic perspective." (P App 89a)

The claim file also contained the following medical evidence and opinions regarding Petitioner's psychiatric/psychological complaints:

> *Mary K. Fisher, Psy. D.:* Dr. Fisher is a psychologist who saw Petitioner on a referral from Dr. Melby. Dr. Fisher performed psychological tests on Petitioner on November 22, 2002. She concluded that Petitioner "suffer[ed] from deficits in executive functioning including sequencing, planning, mental organization, and metal [*sic*] deficits" and that Petitioner "meets the criteria for a DSM-IV diagnosis of dementia due to traumatic brain injury." (P App 66a)

> *Reginald A. Givens, M.D.:* Dr. Givens is a psychiatrist who reviewed Petitioner's medical records at the request of Respondent. In a report dated October 15, 2002, he concluded that the history and testing did support the diagnosis of the treating physician, but "according to objective evidence in the medical records, [Petitioner] does not have a significant impairment that would prevent him from performing essential functions of his employment" and that "[t]here are no specific limitations regarding ability to function related to [Petitioner's] impairments." (P App 90a)